

# Medical Consultation Request Form

Date reported to  
health department

Date Submitted:		Submitter Name:	
LHP* Requesting Consult:		Submitter Location:	
Nurse Case Manager (if different from submitter):			
Briefly Describe Reason for Consult:			
<b>Demographics</b>			
Patient Name:		Date of Birth:	Age:
Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female    Comments:			
<b>Patient History</b>			
Current ATS Classification:		<input type="checkbox"/> 3 – M. TB Infection, Current Disease <input type="checkbox"/> 4 – M. TB, No Current Disease <input type="checkbox"/> 5 – M. TB Suspect, Diagnosis Pending	
<input type="checkbox"/> 0 – No M. TB Exposure, Not TB Infected <input type="checkbox"/> 1 – M. TB Exposure, No Evidence of TB Infection			
History of Present Illness:			
Baseline Weight/BMI:		Current Weight:	
TB Signs and Symptoms:			
<input type="checkbox"/> Cough: <input type="checkbox"/> Productive <input type="checkbox"/> Non-productive <input type="checkbox"/> SOB <input type="checkbox"/> Chest Pain <input type="checkbox"/> Hemoptysis		<input type="checkbox"/> Fever/Chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Weight loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Other:	
Co-morbidities:		Non-TB Medications:	
TB History and Risk Factors (e.g., previous TB treatment with regimen details, foreign born, incarceration, etc.):			
<b>Diagnostics</b>			
<b>Test type</b> includes: smear, pathology/cytology, NAA, culture, TST, IGRA			
<b>Specimen source</b> includes: sputum or other specific anatomic site (e.g., CSF fluid, gastric aspirate, etc.)			
Date Collected	Test Type/Specimen Source	Results	
Date of Sputum Smear Conversion:			
Date of Sputum Culture Conversion:			

\*LHP is the licensed healthcare provider (e.g., treating physician) medically managing the patient

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Chest X-Ray  Other Imaging, Specify:  
Date:  Normal  Cavitory  Non Cavitory  
Read:  
  
Date:  Normal  Cavitory  Non Cavitory  
Read:

## Laboratory Testing

*(attach results or indicate any concerns below)*

HIV Results:  Negative  Positive CD4: Viral load:  
Serum Drug Levels:  Yes  No  Pending  
Lab Results *(list significant results, or submit copy of lab reports):*

## Toxicity Assessments

*(provide abnormal results or changes; attach abnormal results if applicable)*

Date of Most Recent Assessment:  
 Normal  Abnormal  
Trends/Concerns:

## Treatment

*(provide drug-o-gram or equivalent if drug resistant)*

Initial Treatment Start Date: Initial Treatment Stop Date:  
Administration:  DOT  Other Frequency:  5x/week  7x/week  3x/week  
 INH \_\_\_\_\_ mg  BDQ \_\_\_\_\_ mg  LFX \_\_\_\_\_ mg  Other \_\_\_\_\_ mg  
 RIF \_\_\_\_\_ mg  Pa \_\_\_\_\_ mg  CFZ \_\_\_\_\_ mg  Other \_\_\_\_\_ mg  
 PZA \_\_\_\_\_ mg  LZD \_\_\_\_\_ mg  CS \_\_\_\_\_ mg  
 EMB \_\_\_\_\_ mg  MFX \_\_\_\_\_ mg  B6 \_\_\_\_\_ mg

*If different from above:*

Treatment Start Date: Treatment Stop Date:  
Administration:  DOT  Other Frequency:  5x/week  7x/week  3x/week  
 INH \_\_\_\_\_ mg  BDQ \_\_\_\_\_ mg  LFX \_\_\_\_\_ mg  Other \_\_\_\_\_ mg  
 RIF \_\_\_\_\_ mg  Pa \_\_\_\_\_ mg  CFZ \_\_\_\_\_ mg  Other \_\_\_\_\_ mg  
 PZA \_\_\_\_\_ mg  LZD \_\_\_\_\_ mg  CS \_\_\_\_\_ mg  
 EMB \_\_\_\_\_ mg  MFX \_\_\_\_\_ mg  B6 \_\_\_\_\_ mg

Any Additional Comments for this Consultation Request: