

Medical Consultation Request Form

Date reported to health department

LHP* Requesting Consult:       Submitter Location:         Nurse Case Manager (if different from submitter):       Briefly Describe Reason for Consult:         Briefly Describe Reason for Consult:       Date of Birth:         Age:       Sex at Birth:       Male         Patient Name:       Date of Birth:       Age:         Sex at Birth:       Male       Female       Comments:         Patient History       Gurrent ATS Classification:       3 - M. TB Infection, Current Disease         0 - N of M. TB Exposure, Not TB Infected       4 - M. TB, No Current Disease       1 - M. TB Exposure, No Evidence of TB Infection       5 - M. TB Suspect, Diagnosis Pending         History of Present Illness:       Baseline Weight/BMI:       Current Weight:       TB         Baseline Weight/BMI:       Current Weight:       Fatigue       SOB         Sobs       Night sweats       Other:       Other:         Sough:       Productive       Non-productive       Fatigue         Hemoptysis       Weight loss       Co-morbidities:       Non-TB Medications:         TB History and Risk Factors (e.g., previous TB treatment with regimen details, foreign born, incarceration, etc.):       Diagnostics         Diagnostics         Test type includes: sputum or other specific anatomic site (e.g., CSF fluid, gastric aspirate, etc.) <th>Date Submitted:</th> <th colspan="2">Submitted: Submitter Name:</th> <th></th>	Date Submitted:	Submitted: Submitter Name:					
Briefly Describe Reason for Consult:     Demographics     Patient Name:   Date of Birth:   Age:   Sex at Birth:   Male   Female   Current ATS Classification:   0 - No M. TB Exposure, Not TB Infected   1 - M. TB Exposure, No Evidence of TB Infection   I - M. TB Exposure, No Evidence of TB Infection   History of Present Illness:   Baseline Weight/BMI: Current Weight: TB Signs and Symptoms: Cough:   Curent Productive   Patient Misk seats   Other:   Chest Pain   Hemoptysis   Co-morbidities:   Non-TB Medications: TB History and Risk Factors (e.g., previous TB treatment with regimen details, foreign born, incarceration, etc.):	LHP* Requesting Co	onsult:					
Demographics         Patient Name:       Date of Birth:       Age:         Sex at Birth:       Male       Date of Birth:       Age:         Sex at Birth:       Male       Female       Comments:       Patient History         Current ATS Classification:       0       3       - M. TB Infection, Current Disease         0       - No M. TB Exposure, No TB Infected       0       4       - M. TB, No Current Disease         1       - M. TB Exposure, No Evidence of TB Infection       0       5       - M. TB Suspect, Diagnosis Pending         History of Present Illness:	Nurse Case Manager (if different from submitter):						
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Date Collected       Test Type/Specimen Source       Results         Image: Collected       Image: Collected       Image: Collected         Image: Collected       Image: Collected       Image: Collected       Image: Collected         Image: Collected       Image: Collected       Image: Collected       Image: Collected       Image: Collected         Image: Collected       Image: Collected       Image: Collected       Image: Collected       Image: Collected         Image: Collected<							
Image: Constraint of the second se	Date Collected	Test Type/Specime	n Source	Results			
Image: Constraint of the second sec							
Date of Sputum Smear Conversion:							
Date of Sputum Culture Conversion:							

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



## Medical Consultation Request Form

Date reported to health department

□ Chest X-Ray □ Other Imaging, Specify: Date: □ Normal □ Cavitary □ Non Cavitary Read:				
ead:				
<b>Laboratory Testing</b> (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):				
(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 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:         Administration:       DOT         Other       Frequency:       5x/week       7x/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:       Any Additional Comments for this Consultation Request:				