

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:					
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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:				
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):				
(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:				