TB CASE/SUSPECT REPORT

FDOH
in Miami-Dade County

1 Reporting Entity

Reporting Date (MM/DD/YYYY) ☐ Suspect ☐ New Case ☐ Reactivation ☐ Transfer

Entity Name

( ) Entity Phone Number

( ) Entity Fax Number

Reported by (Last Name, First Name)

2 Patient Demographics & Current Address

Last Name | First Name | Mi

Current Address (Number & Street Name) | Apt. Number

City | State | Zip Code

( ) Home Phone Number

Country of Origin

If not US, Date arrived in USA: / / Format (MM/DD/YYYY or MM/YYYY)

Florida Resident: ☐ Yes ☐ No

If Yes, Date Arrived in Florida: / / Format (MM/DD/YYYY or MM/YYYY)

Date of Birth (MM/DD/YYYY) | Social Security Number

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married

Race: ☐ Amer. Ind. Or Alaskan Native ☐ Asian or Pacific Isl. ☐ Black ☐ White

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Language Spoken if NOT English:

Homeless within past year: ☐ Yes ☐ No

Status at Diagnosis of TB: ☐ Alive ☐ Dead

3 Previous Address: *(Fill only if less than 6 months in Current Address)*

Previous Address (Number & Street Name) | Apt. Number | City | State | Zip Code

4 Occupation *(Check all that apply within the past 24 months.)*

☐ Health Care Worker ☐ Correctional Employee ☐ Migratory Agricultural Worker ☐ Unknown

☐ Student ☐ School Staff ☐ Restaurant Worker ☐

☐ Not Employed within the past 24 months. ☐ Other Occupation (specify)

5 Workplace

Institution Name | Suite Number

Number & Street Name | City

State | Zip Code | ( ) - Work Phone Number

6 Past Medical (TB) History

☐ Yes ☐ No If Yes, When (Year) **Where:** Country, State or County

Med Taken: ☐ 1 Drug ☐ 2 or more Drugs

Duration of Rx. | Specify (drug Name)

Previous IGRA: ☐ Pos ☐ Neg ☐ Indeterminate Collection Date / /

Previous PPD: ☐ Positive If + Size in mm. ☐ Negative PPD Date (MM/YYYY) / /

7 Current Supervision/ Meds./ IGRA & X-ray

Meds. Supervision:

Physician's / Institution's Name

( ) - Phone Number | ( ) - Fax Number

Admission Date (MM/DD/YYYY) | Discharge Date (mm/DD/YYYY)

Chest X-ray Date (MM/DD/YYYY) Results: ☐ Normal ☐ Abnormal ☐ Cavitary

Chest X-ray Comments.

Current TB Meds. Dosage/mg.: | TB Medications Start Date

Other Medications & Dosage

Current Non-TB Medications | **Patient's weight:** In Lbs.

Current IGRA: Collection Date (MM/DD/YYYY) ☐ Positive ☐ Negative

Reporting Date (MM/DD/YYYY) / / ☐ Indeter

8 Bacteriology

Specimen: ☐ Sputum ☐ Other Tissue/Fluid

Smear: ☐ Pos. ☐ Neg.

Culture: ☐ Pos. ☐ Neg. Result Date *(Diagnosis Date)*

/ / Culture ID

Lab Name

( ) - Lab Phone Number | ( ) - Lab Fax Number

9 Site(s) of Disease

☐ Pulmonary ☐ Lymphatic Unknown ☐ Lymphatic Cervical ☐ Lymphatic Intrathoracic ☐ Lymphatic Other

☐ Pleural ☐ Bone & or Joint ☐ Genitourinary ☐ Miliary ☐ Meningeal

☐ Peritoneal ☐ Other (Specify)

10 HIV Status

☐ Positive ☐ Negative ☐ Indeterminate ☐ Refused ☐ Not Offered

☐ Test Done Results Unknown **If Positive, Based on :** ☐ Medical Documentation ☐ Patient History

Send report to: MDCHD/TB Program 1350 NW. 14th. Street, Miami, FL 33125 Fax: (305) 575-3804
If you have any questions or need clarification about this form, contact: (305) 575-5415

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11 Symptoms

☐ Asymptomatic ☐ Wt. Lost ____ Lbs. (Amount) Over ____ (Months) ☐ Pleurisy
☐ Cough ☐ Fatigue ☐ Hemoptysis ☐ Fever ☐ Anorexia ☐ Fistula
☐ Night Sweat ☐ Shortness of breath ☐ Other _____

12 Alcohol / Drug Use

Intra-Venous drug use: ☐ Yes ☐ No Date Last Use (MM/YYYY)
Non-Injection drug Use within past year: ☐ Yes ☐ No Date Last Use (MM/YYYY)
Excess Alcohol Use within past year: ☐ Yes ☐ No Date Last Use (MM/YYYY)

13 Contact to TB Case

Ever Exposed to a TB Case? ☐ Yes ☐ No How long? ____ (Months) Last Name First Name Relationship
Did any family member die with TB? ☐ Yes ☐ No Date of last Contact: / (Format (MM/YYYY))

14 Other Medical Conditions

Previously Diagnosed with Liver Disease: ☐ Yes ☐ No
If "**Yes**", What & When? / (Format (mm/yyyy))
☐ Gastrectomy ☐ Diabetes Mellitus ☐ Renal Failure
☐ Organ Transplant ☐ Pregnant Expected time of Delivery /
☐ Epilepsy / (Last Episode Date (mm/yyyy)) ☐ Allergies Name
☐ Immunosuppressive Medications ☐ Silicosis (Occupational Lung Disease)
☐ Jejuoileal Bypass ☐ Cancer of Head, Neck or Lung
☐ Other, Specify

15 Correctional Facility

(A) Was the client incarcerated during their infectious period: ☐ Yes ☐ No
If '**Yes**', Where ?: ☐ Federal Prison ☐ Local Jails ☐ Other Correctional Facility ☐ State Prison ☐ Juvenile Correctional Facility
Correctional Facility Name
( ) - Correctional Facility Phone Number ( ) - Correctional Facility Fax Number

16 Long Term Care Facility

(A) Resident of Long-Term Care Facility at time of Diagnosis: ☐ Yes ☐ No
(B) Resident of Long-Term Care Facility within the last 2 Years: ☐ Yes ☐ No
If '**Yes**' to **A** or **B**: ☐ Nursing Home ☐ Hospital ☐ Residential ☐ Mental Health ☐ Alcohol/Drug Treatment ☐ Other Long Term Care Facility
Long Term Care Facility Name
( ) - Long Term Care Facility Phone Number ( ) - Long Term Care Facility Fax Number

17 Emergency Contacts

Last Name | First Name | Relationship | (Phone Number | Other Information
Last Name | First Name | Relationship | ( ) - Phone Number | Other Information

18 Comments

FOR DOH USE ONLY

TB IMS Case Number: Current Year -
Within City Limit: ☐ Yes ☐ No
Diagnosis for Case Register
/ / Date Submitted to Tallahassee
County Case Number

Report Received by: Last Name First Name
/ / Interview Date
Interviewer's Name Interviewer's Signature

Updated by

1. Name Date (mm/dd/yyyy) /
2. Name Date (mm/dd/yyyy) /
3. Name Date (mm/dd/yyyy) /
4. Name Date (mm/dd/yyyy) /

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