MONTHLY TUBERCULOSIS FOLLOW-UP REPORT

State Form 48092 (R5 / 4-22)
INDIANA DEPARTMENT OF HEALTH

Information on this form is confidential pursuant to 410 IAC 1-2.5-78.

Reset Form

INSTRUCTIONS: Complete this form monthly for all patients being treated for tuberculosis (TB) disease and attach to patient's investigation in NBS.

1. Patient's Name	2. Time Period of Report *(month and day)* to
3. Date of Birth *(mm/dd/yyyy)*	4. County
5. Date therapy began *(mm/dd/yyyy)*	6. Date of last patient encounter with nurse *(month, day, year)*
7. Expected Treatment duration: Month number_____of ☐ 6m ☐ 9m ☐ Other	8. For final reports, treatment was completed on *(month, day, year)*:

9. TB symptoms. ***Check all that were present during the most recent visit.***

☐ Cough	☐ Weight loss	☐ Chest Pain	☐ Night sweats	☐ Hemoptysis
☐ Fever	☐ Chills	☐ Other *(specify)*	☐ No symptoms	
Describe other symptoms, if present.				
Overall condition since beginning treatment: ☐ **Improving** ☐ **Worsening** ☐ **Stable**				

10. Prior month's treatment regimen

Medication	**Dose (mg)**	**Medication Frequency**	**Start Date** *(mm/dd/yyyy)*	**End Date** *(mm/dd/yyyy)*	**DOT Frequency During Last Month**	**Previous Month DOT Doses Completed***		**Total DOT Doses Completed***	
						Initial Phase	**Continuation Phase**	**Initial phase**	**Continuation phase**
Isoniazid (INH)					☐ Daily, 7 days / week				
Rifampin (RIF)									
Pyrazinamide (PZA)					☐ 5 days / week, self-administer on weekends				
Ethambutol (EMB)									
Rifabutin (RFB)					☐ 5 days / week, no weekend doses				
Rifapentine (RPT)									
Vitamin B_6									
Other:					☐ Three times weekly				

** Please attach DOT log.*

11. Next month treatment plan (medications, dosage, frequency, DOT): ☐ No change expected from above ☐ Expecting change

Explain any changes: _____

_____

12. Patient's current weight: _____ pounds ÷ 2.2 = _____ kilograms

13. If pulmonary case is sputum culture positive, sputum should be collected regularly until culture converts. Is culture conversion documented? ☐ Yes ☐ No **If no, most recent sputum collection dates *(mm/dd/yyyy)*:** _____

(Check one) ☐ Collected and sent to IDOH ☐ Collected and sent to another laboratory *(Please send lab results to IDOH.)*

Name of laboratory:_____

☐ Not collected; *briefly explain why*: _____

14. Date of last patient encounter with the physician *(mm/dd/yyyy)*: _____ *(Attach visit notes)*

15. Chest radiograph taken since last report? ☐ Yes *(Attach dictated report)* ☐ No

16. Have other diagnostic studies been performed since the last report? ☐ Yes *(Attach results)* ☐ No

17. Comments (medication side effects, changes in the treatment plan, etc.)

18. Signature of Case Manager: _____ **Date *(mm/dd/yyyy)*:** _____

Instructions

1. Enter the patient's name.

2. Enter the specific dates *(month and day)* for the thirty (30) day time period this report covers.

3. Enter the month, day, and year of birth.

4. Enter the county in which the patient resides.

5. Enter the date therapy initially began. If the regimen has to be restarted because of treatment lapses, explain in question number 17.

6. Enter the date that you last visited the patient.

7. Enter the month of therapy, e.g. 1, 5, 6, etc. and length of expected treatment duration.

8. For completion of treatment, enter the date that the last dose of medication was ingested.

9. Check all symptoms that the patient had during the most recent visit. Site-specific extra-pulmonary symptoms can be explained in the "other symptoms" comment box. Select one category that generally describes the patient's overall condition.

10. Enter the drugs and the dosage that make up the patient's prior thirty (30) day treatment regimen. Check the appropriate box for directly observed therapy (DOT) and frequency of administration. If the patient is not on DOT, please explain why not. Therapy administered by a friend or family member is not DOT. *Please attach a copy of the DOT log for the reporting period.*

11. For the next thirty (30) day treatment, indicate if you are expecting any changes in medication, dosage, frequency and DOT. Please explain any anticipated changes.

12. Enter the patient's current weight.

13. For pulmonary TB patients, enter the applicable sputum collection information. For patients who are still AFB smear-positive and have not had sputum collected recently, or who do not yet have documentation of negative sputum cultures, please explain why sputum is not being collected.

14. Enter the date of the last conversation you had with the patient's physician. Attach notes from patient visit, if applicable.

15. For patients with pulmonary or other intrathoracic disease, enter whether or not a chest radiograph has been performed since the initial one. If yes, attach the dictated report.

16. Enter if any other diagnostic tests have been performed.

17. If needed, enter any comments, e.g., changes in the treatment plan, non-adherence issues, medication side effects, etc.

18. Sign and date the form. **Upload and attach form to patient's TB Investigation in NBS.** Please e-mail your regional nurse consultant to alert them to the availability of the monthly report submission.