MONTHLY TUBERCULOSIS FOLLOW-UP REPORT

State Form 48092 (R3 / 11-08)
INDIANA STATE DEPARTMENT OF HEALTH

Reset Form

Information on this form is confidential pursuant to IC 16-41-8-1
Fax to: ISDH TB Division 317.233.7747

INSTRUCTIONS: refer to the back of the form.

1. Name of patient:	
2. Date of birth:	**3. County:**
4. Date therapy began:	**5. Date of last patient encounter with nurse:**
6. Expected treatment duration: **Month # of ☐ 6m ☐ 9m ☐ other**	**7. For final reports, treatment was completed on:**

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

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

9. Prior months treatment regimen

Medication	Dose (mg)	Medication Frequency	Start date	End date	DOT Frequency during last month	DOT Doses completed	
						Initial phase	Continuation phase
Isoniazid (INH)					☐Daily, 7 days/week ☐5 days/week, self-administer on weekends ☐Three times weekly ☐Twice weekly ☐One day a week		
Rifampin (RIF)							
Pyrazinamide (PZA)							
Ethambutol (EMB)							
Rifabutin (RFB)							
Rifapentine (RPT)							
Vitamin B_6							
Other:							

10. Next month treatment plan (medications, dosage, frequency, DOT): ☐ No change expected from above ☐ Expecting change
Explain any changes: _____

_____

11. Patients current weight: _____ pounds ÷ 2.2 = _____ kilograms

12. If pulmonary case is sputum culture positive, sputums should be collected regularly until culture converts. Is culture conversion documented ☐ Yes ☐ No **If no, most recent sputum collection dates**: _____
(Check one) ☐ collected & sent to ISDH ☐ collected & sent to another laboratory *(please send lab results to ISDH)*
Name of laboratory: _____
☐ not collected; briefly explain why: _____

13. Date of last conversation with the physician: _____ **14. Date the patient was last seen by the physician: _____**

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: _____

Instructions

A monthly Tuberculosis follow-up Report should be completed and faxed to ISDH TB/Refugee Program after each 30 days of treatment.

1. Enter the patient's name.

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

3. Enter the county the patient resides in.

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

5. Enter the date that you last visited the patient. Do not leave blank.

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

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

8. Do not leave blank. 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.

9. Enter the drugs and the dosage that make up the patient's prior 30 day treatment regimen. Check the appropriate box for directly-observed therapy 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.

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

11. Enter the patient's current weight.

12. 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 at least 2 consecutive negative sputum cultures please explain why sputum is not being collected.

13. Enter the date of the last conversation you had with the patient's physician.

14. Enter the date the patient was last seen by his or her physician.

15. For patients with pulmonary or other intrathoracic disease, enter whether or not a chest radiograph has been performed since the initial one. If so, 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. **Fax form to ISDH TB Division 317.233.7747**.