

Individual Tuberculosis Report

(OVER)

HIV STATUS: ☐ Negative ☐ Refused
 ☐ Positive ☐ Not Offered
 ☐ Indeterminate ☐ Test Done, Results Unknown

If Positive, Based on: ☐ Medical Documentation ☐ Patient History

RESIDENT OF CORRECTIONAL FACILITY AT TIME OF DIAGNOSIS: ☐ No ☐ Yes

If Yes: ☐ Federal Prison ☐ Local Jail ☐ Other Corr. Facility
 ☐ State Prison ☐ Juvenile Corr. Facility

RESIDENT OF LONG-TERM CARE FACILITY AT TIME OF DIAGNOSIS: ☐ No ☐ Yes

If Yes: ☐ Nursing Home ☐ Mental Health Res. Facility
 ☐ Hospital-Based Facility ☐ Alcohol or Drug-Treatment Facility
 ☐ Residential Facility ☐ Other Long-Term Care Facility

ILLEGAL NON-INJECTING DRUG USE WITHIN PAST YEAR: ☐ No ☐ Yes

ILLEGAL INJECTING DRUG USE WITHIN PAST YEAR: ☐ No ☐ Yes

EXCESS ALCOHOL USE WITHIN PAST YEAR: ☐ No ☐ Yes

INITIAL DRUG REGIMEN:

	No	Yes	Unk.	Dosage	Date Therapy Started
Isoniazid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifampin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pyrazinamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethambutol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Streptomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethionamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kanamycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cycloserine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Capreomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Para-Amino	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salicylic Acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amikacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifabutine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____ (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Reported By _____ Date _____