Alaska TB Program
Section of Epidemiology
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TB Case Management Information Request

To: _____ Date ____ / ____ / _____

From: _____

Patient: _____ DOB ____ / ____ / _____

Review of our records indicates that we are in need of the following:

_____ Occupation _____

_____ Race: White ☐ Black ☐ Native ☐ Asian ☐

_____ Ethnicity: Hispanic ☐ Non-Hispanic ☐

_____ Birth country: _____Arrival date: ___/___/_____

_____ TST: Date ____ / ____ / ____Results (mm) _____

_____ IGRA: Date ____ / ____ / ____ Results: ☐ pos. ☐ neg. ☐ indeterminate

_____ Primary provider's initial chart notes / H & P

_____ CXR Report(s)

_____ CT / MRI Report(s)

_____ Conversion sputa

_____ HIV status: Date ____ / ____ / _____Results_____Not Offered ☐ Refused ☐

_____ History of LTBI? Yes ☐ No ☐ Date ___/___/_____

_____ History of Active TB? Yes ☐ No ☐ Date ___/___/_____

_____ Homeless within last year? Yes ☐ No ☐

_____ In correctional facility at diagnosis? Yes ☐ No ☐

_____ In long term care facility at diagnosis? Yes ☐ No ☐

_____ Excess alcohol within past year? Yes ☐ No ☐

_____ Non-injecting drug use within past year? Yes ☐ No ☐

_____ Injecting drug use within past year? Yes ☐ No ☐

_____ Smokes cigarettes? Yes ☐ No ☐ Packs/day _____

_____ Diabetes? Yes ☐ No ☐

_____ Initial *Contact Investigation Form*

_____ Final *Contact Investigation Form*

_____ DOT Calendars: J F M A M J J A S O N D

_____ End of therapy date: ____ / ____ / _____

_____ Other _____

THANK YOU