For local health department use only CDESS/HIN SERIAL NUMBER:_____

TB PATIENT INTAKE SHEET

NAME: _____ _____ **DOB:** _____
Last Name **First Name**

ALIAS/AKA: _____

ADDRESS (include apt #): _____

CITY: _____ **ZIP CODE:** _____ **TEL. # (home/work/cell):**_____

LENGTH OF TIME: at current address _____ **In Westchester County**_____ **In New York State**_____

BIRTHPLACE (CITY/COUNTRY): _____ **DATE ENTRY USA:** _____ **FOREIGN RESIDENT** ☐**Y** ☐**N** ☐**UNK**

RACE: _____ **ETHNICITY:** _____ **SEX:** _____ **PREGNANT** ☐**Y** ☐**N**

OUTCOME: ☐**ALIVE** ☐**DEAD** **DATE OF DEATH:** _____ **CAUSE OF DEATH:** _____

OCCUPATION: ☐**FOOD SERVICE** ☐**DAY CARE** ☐**HEALTH CARE** ☐**STUDENT/SCHOOL** ☐**INMATE**
☐**CORRECTION WORKER** ☐ **OTHER**_____

NAME OF EMPLOYER: _____ **LAST DAY OF WORK:** _____

NAME OF REPORTING INDIVIDUAL: _____ **REPORT DATE:** _____

REPORTING SOURCE: ☐**LOCAL HEALTH UNIT** ☐**MD** ☐**HOSPITAL/ICN** ☐**LAB** ☐**OTHER**
☐**DEATH CERTIFICATE** ☐**FEDERAL INSTITUTION** ☐**OTHER STATE HEALTH DEPT**

MD: _____ **MD PHONE #:** _____

HOSP: _____ **ADM DATE:** _____ **DISCHARGE DATE:** _____

ADMIT DIAGNOSIS (list all): _____

MEDICAL RECORD#: _____ **INSURANCE:** _____ **Policy #:** _____

PERSON WHO WILL NOTIFY HEALTH DEPT OF DISCHARGE: _____

BACTERIOLOGY

REPORTING LAB	SPEC:	DATE:	LAB#:	SMEAR:	PROBE:	CULT:
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

CXR/CT SCAN (submit reports): ☐**Normal (**☐**CXR** ☐**CT scan)** ☐**Abnormal (**☐**CXR** ☐**CT scan)** **Cavitary Y/N** **(**☐**CXR** ☐**CT scan)**

TST (DATE ADMINISTERED/ RESULT IN MM): _____ **IGRA/ QFT-G (DATE/RESULT)** _____

HIV: DATE TESTED/RESULTS: _____ **DATE PATIENT PLACED ON ISOLATION:** _____

DATE OF TB DIAGNOSIS: _____ **PAST HX OF TB:** ☐ **Y** ☐**N** **If yes: Date:** _____ **Location (city, state, or country)**_____

SITE OF TB INFECTION (list all):_____ **WEIGHT:** _____

MEDS: **INH date** _____ **dosage**_____ **RIF date** _____ **dosage**_____ **PZA date** _____ **dosage**_____

EMB date _____ **dosage**_____ **Other TB meds** _____ **date** _____ **dosage**_____

DATE OF FIRST SYMPTOM: _____ **HISTORY (SYMPTOMS ETC.):** _____

EMERGENCY CONTACT/NEXT OF KIN (NAME/PHONE NUMBER):_____

ADDITIONAL COMMENTS_____

WCDOH Disease Control Nurse _____ Date report received_____

For local health department use only Case Status: ☐Confirmed ☐Suspect

rev. 1/2012