REPORT/CONSULTATION FORM FOR PEDIATRIC TUBERCULOSIS CASE

If this is a suspicious case for active TB, please call TB Control immediately at 215-685-6873

Report Date: _____/_____/_____

PCP Name (print):_____
Health Center #:___ *or* PCP Office Phone:_____
Fax #: _____

Place Patient's Sticker Here

Patient Information

Patient's Last Name:	Date of Birth: _____/_____/_____ Age:_____ years
First & Middle Name:	Gender ☐Male ☐Female
Patient's Weight: _____ ☐lb ☐kg	Allergies: ☐NKDA
Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino	Medications:
Race ☐White ☐Black ☐Asian ☐American Indian/Alaska Native ☐Native Hawaiian/Other Pacific Islander ☐Other	Did Patient Ever Receive BCG Vaccination? ☐Unknown ☐No ☐Yes (Date: _____/_____/_____)
Current Address:_____ Apt # _____ Philadelphia, PA ZIP: _____	Country of Patient's Birth: _____ Year Patient Arrived in U.S.: _____ ☐N/A
Phone Number (Home/Other): _____ (Work): _____ (Cell): _____ ☐Patient's ☐Parent's	Name of Primary Guardian(s):_____ _____
School Name: _____	Country of Primary Guardian's Birth: _____ Year Primary Guardian Arrived in U.S.: _____ ☐N/A

Test Information

Tuberculin Skin Test (TST): Date TST Placed: ____/____/____ Date TST Read: ____/____/____ TST Results: Specify size: _____ mm	LFT's (AST, ALT, GGT, AP) Done? ☐No ☐Yes (Date: ____/____/____) CBC Done? ☐No ☐Yes (Date: _____/_____/_____)
Date of CXR: _____/_____/_____ Results: ☐Normal ☐Abnormal (Non-cavitary) ☐Abnormal (Cavitary)	Was Hep B Panel Ordered (HBsAg, Anti-HBs, Anti HBc)? ☐No ☐Yes Were Hepatitis C Antibodies Ordered (anti-HCV)? ☐No ☐Yes
If Patient with Chronic Cough and >8 Years, was Baseline Sputum Collected? ☐Yes ☐No ☐N/A	HIV Test Ordered? ☐No ☐Yes (Date: _____/_____/_____) Mother's HIV Status: ☐Unknown ☐Negative ☐Positive

Risk Factors

Primary Reason Tuberculin Skin Test (TST) Placed: ☐Routine Screening ☐TB Symptoms
☐Household Member with LTBI ☐Contact of Active TB Case ☐Household Member with Increased Risk of TB Exposure
☐Recent Hx of Detention, Incarceration, Shelter Stay ☐Travel to TB Endemic Area ☐Other (explain below)

Has the Patient Lived or Traveled Outside the U.S. for 2 or More Months? ☐No ☐Yes

Physician Request

Type of DOPT (Directly Observed Preventive Therapy) Requested: ☐In-Home (ages ≤5 yrs) ☐School-Based ☐None (explain below)	Special Request for Contact Investigation and/or TST Placement of Household Members: ☐No ☐Yes (explain below)

PCP Comments/Questions/Explanations:

- THIS SECTION FOR TB CONTROL RESPONSE -

SELECT: ☐Active TB Regimen ☐Latent TB Infection Regimen
☐Rifampin* ☐INH* *Dosage: _____mg ☐Daily ☐Twice a Week

DOPT: ☐No ☐Yes (Specify where): ☐Home ☐School ☐Flick Center
If School-Based DOPT, When Will it Start? ☐Within 1-4 Weeks ☐In Fall (of next school year)

Flick Center Appointment Made? ☐No (not necessary) ☐No (not yet) ☐Yes (for the following date: ____/____/____)

Comments/Notes to PCP:

Please fax this reporting form, official CXR reading, and all lab reports (LFT's, CBC, HIV, and others) to TB Control at 215-685-6477