GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
TUBERCULOSIS CASE REPORT

Name:	SSN#	Date of Report:
Address:	Telephone #	Date of Birth:

Marital Status:	Sex:	Race:	Country of Origin if not U.S.
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	☐ Female ☐ Male	☐ Black ☐ American Indian or Alaskan Native ☐ White ☐ Asian or Pacific Islander **Ethnic Origin:** ☐ Hispanic ☐ Not Hispanic ☐ Define _____	_____ **Date arrive in U.S.** _____

Occupation	Place of Employment	Address

Classification

☐ Tuberculosis current disease
☐ Tuberculosis No current disease
☐ Tuberculosis suspect
☐ Tuberculosis infection No disease

Signs and Symptoms:

_____

_____

Diagnosis

☐ Pulmonary
☐ Non-Pulmonary
☐ Miliary ☐ Meningitis
☐ Bones and Joints ☐ Pleural
☐ Lymphatic ☐ Peritoneal
☐ Genito-Urinary ☐ Other (specify)
☐ Reported at time of death

Immunocompromised
☐ Neg ☐ Pos

Bacteriology

	POS.	NEG.	Pending	Not Done
Smear	☐	☐	☐	☐
Culture	☐	☐	☐	☐

Type of Specimen
☐ Sputum ☐ Fluid
☐ Tissue ☐ Other (specify) _____

_____
(date(s) of collection)

_____
Laboratory Performed

Chest X-Ray

☐ Not done
☐ Normal
☐ Abnormal
  ☐ Cavitary
  ☐ Non-cavitary
☐ Stable
☐ Worsening
☐ Improving

_____
Date of X-Ray
Comments:

Tuberculin Skin Test

☐ Not done
☐ QuantiFERON
☐ T-Spot
☐ Mantoux
☐ Tine
☐ Other (specify) _____
☐ Significant Size (mm) _____
☐ Not significant

_____
Date Read

Chemotherapy Dosage

☐ Isoniazid
☐ Rifampin
☐ Ethambutol
☐ Pyrazinamide
☐ Streptomycin
☐ Other (specify) _____

_____
Date started

Patient to be followed by: _____
(Name) (Address) (Phone)

Previous Diagnosis:
☐ Yes ☐ No
Date: _____

Comments:

☐ Send Additional Report Forms

Hospitalization
Chart No.
Admission Date: _____
Discharge Date: _____

Reported by	Signature	Office or Hospital Address

Source #	Ward	Census Tract	Date Received	Case #	Verified

Revised 01/14 rep

Please fax TB Case Report to (202) 724-2363 Attn: Registry

Print Save Reset