



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 <input type="checkbox"/> Male <input type="checkbox"/> Female
Patient's Weight: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg	Allergies: _____ <input type="checkbox"/> NKDA
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Medications: _____
Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other	Did Patient Ever Receive BCG Vaccination? <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes (Date: ___/___/___)
Current Address: _____ Apt # _____ Philadelphia, PA ZIP: _____	Country of Patient's Birth: _____ Year Patient Arrived in U.S.: _____ <input type="checkbox"/> N/A
Phone Number (Home/Other): _____ (Work): _____ (Cell): _____ <input type="checkbox"/> Patient's <input type="checkbox"/> Parent's	Name of Primary Guardian(s): _____
School Name: _____	Country of Primary Guardian's Birth: _____ Year Primary Guardian Arrived in U.S.: _____ <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes (Date: ___/___/___) CBC Done? <input type="checkbox"/> No <input type="checkbox"/> Yes (Date: ___/___/___)
Date of CXR: ___/___/___ Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Non-cavitary) <input type="checkbox"/> Abnormal (Cavitary)	Was Hep B Panel Ordered (HBsAg, Anti-HBs, Anti HBe)? <input type="checkbox"/> No <input type="checkbox"/> Yes Were Hepatitis C Antibodies Ordered (anti-HCV)? <input type="checkbox"/> No <input type="checkbox"/> Yes
If Patient with Chronic Cough and >8 Years, was Baseline Sputum Collected? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	HIV Test Ordered? <input type="checkbox"/> No <input type="checkbox"/> Yes (Date: ___/___/___) Mother's HIV Status: <input type="checkbox"/> Unknown <input type="checkbox"/> Negative <input type="checkbox"/> Positive

Risk Factors	
Primary Reason Tuberculin Skin Test (TST) Placed: <input type="checkbox"/> Routine Screening <input type="checkbox"/> TB Symptoms <input type="checkbox"/> Household Member with LTBI <input type="checkbox"/> Contact of Active TB Case <input type="checkbox"/> Household Member with Increased Risk of TB Exposure <input type="checkbox"/> Recent Hx of Detention, Incarceration, Shelter Stay <input type="checkbox"/> Travel to TB Endemic Area <input type="checkbox"/> Other (explain below)	
Has the Patient Lived or Traveled Outside the U.S. for 2 or More Months? <input type="checkbox"/> No <input type="checkbox"/> Yes	

Physician Request	
Type of DOPT (Directly Observed Preventive Therapy) Requested: <input type="checkbox"/> In-Home (ages <5 yrs) <input type="checkbox"/> School-Based <input type="checkbox"/> None (explain below)	Special Request for Contact Investigation and/or TST Placement of Household Members: <input type="checkbox"/> No <input type="checkbox"/> Yes (explain below)
PCP Comments/Questions/Explanations: 	

----- THIS SECTION FOR TB CONTROL RESPONSE -----	
SELECT: <input type="checkbox"/> Active TB Regimen <input type="checkbox"/> Latent TB Infection Regimen <input type="checkbox"/> Rifampin* <input type="checkbox"/> INH* *Dosage: _____ mg <input type="checkbox"/> Daily <input type="checkbox"/> Twice a Week	
DOPT: <input type="checkbox"/> No <input type="checkbox"/> Yes (Specify where): <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Flick Center If School-Based DOPT, When Will it Start? <input type="checkbox"/> Within 1-4 Weeks <input type="checkbox"/> In Fall (of next school year)	
Flick Center Appointment Made? <input type="checkbox"/> No (not necessary) <input type="checkbox"/> No (not yet) <input type="checkbox"/> Yes (for the following date: ___/___/___)	
Comments/Notes to PCP: 	