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Missouri Statutes and Regulations Concerning Tuberculosis

Click on the link after the title of the statute to access the complete text from the Revised Statues of the State of Missouri on the Missouri General Assembly’s internet site.

Contagious Diseases Excluded from School (RSMo 167.191)
http://www.moga.mo.gov/mostatutes/stathtml/16700001911.html

Commitment and Hospitalization of Tuberculosis Patients – Rehabilitation-Head Injury – TB Testing
Definitions (RSMo 199.170 – 199.350)
http://www.moga.mo.gov/mostatutes/stathtml/19900001701.html

Local health agency may institute proceedings for commitment (RSMo 199.180)
http://www.moga.mo.gov/mostatutes/stathtml/19900001801.html

Patients not to be committed when (RSMo 199.190)
http://www.moga.mo.gov/mostatutes/stathtml/19900001901.html

Procedure in circuit court—duties of local prosecuting officers—costs (RSMo 199.210)
http://www.moga.mo.gov/mostatutes/stathtml/19900002001.html

Rights of Patient, witnesses—order of course—transportation costs (RSMo 199.210)
http://www.moga.mo.gov/mostatutes/stathtml/19900002101.html

Order appealable (RSMo 199.220)
http://www.moga.mo.gov/mostatutes/stathtml/19900002201.html

Confinement on order, duration (RSMo 199.230)
http://www.moga.mo.gov/mostatutes/stathtml/19900002301.html

Consent required for medical or surgical treatment (RSMo 199.240)
http://www.moga.mo.gov/mostatutes/stathtml/19900002401.html

Facilities to provided—costs, how paid (RSMo 199.250)
http://www.moga.mo.gov/mostatutes/stathtml/19900002501.html

Apprehension and return of patient leaving rehabilitation center without discharge (RSMo 199.260)
http://www.moga.mo.gov/mostatutes/stathtml/19900002601.html

Proceedings for release of patient (RSMo 199.270)
http://www.moga.mo.gov/mostatutes/stathtml/19900002701.html

Tuberculosis Screening for Residents and Workers in Nursing Homes (RSMo 199.350)
http://www.moga.mo.gov/mostatutes/stathtml/19900002901.html
Missouri Regulations Concerning Tuberculosis

The Code of State Regulations, or rules, is available on the Missouri Secretary of State’s web site in PDF format. Regulations are organized by title, division, chapter, and section. For example, 19 CSR 20-20.020 refers to Title 19, Division 20, Chapter 20, Section 020. The links that follow take the user to the appropriate division and chapter of the regulations. Scroll to the specific section number.

19 CSR 20-20.010 Definitions Relating to Communicable, Environmental and Occupational Diseases
19 CSR 20-20.020 Communicable, Environmental and Occupational Diseases
19 CSR 20-20.030 Exclusion from School and Readmission
19 CSR 20-20.040 Measure for the control of Communicable, Environmental and Occupational Diseases
19 CSR 20-20.050 Quarantine or Isolation Practices and Closing of Schools and Places of Public and Private Assembly
19 CSR 20-20.070 Duties of Local Health Departments
19 CSR 20-20.080 Duties of Laboratories
19 CSR 20-20.090 Contact with Communicable Diseases by First Responders or Emergency Medical Persons and Mortuary Personnel
19 CSR 20-20.100 Tuberculosis Testing for Residents and Workers in Long-Term Care Facilities and State Correctional Centers


Chapter 61--Licensing Rules for Family Day Care Homes

19 CSR 30-61.010 Definitions
19 CSR 30-61.125 Medical Examination Reports
http://s1.sos.mo.gov/cmsimages/adrules/csr/current/19csr/19c30-61.pdf

Chapter 62—Licensing Rules for Group Day Care Homes and Child Day Care Centers

19 CSR 30-62.010 Definitions
19 CSR 30-62.122 Medical Examination Reports
http://s1.sos.mo.gov/cmsimages/adrules/csr/current/19csr/19c30-61.pdf

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Educational Materials

Ordering Educational Materials

Educational materials may be ordered through the Section for Disease Prevention, Bureau of Communicable Disease Control and Prevention. To place an order, call the Bureau at (573) 526-5832.

To order literature from the Department of Health and Senior Services warehouse, go to http://health.mo.gov/warehouse/e-literature.html.

CDC Educational Material and Internet Resources

The CDC has prepared a useful list of education resources. You can access it at https://wwwn.cdc.gov/pubs/CDCInfoOnDemand.aspx
Medication Fact Sheet – Isoniazid (INH)

It is important to take this medication for the full time of treatment. It is important that you do not miss any doses. If you do miss a dose, take it as soon as possible. However, if it is almost time for your next dose, skip the missed dose and go back to your regular schedule. **DO NOT** double dose.

**To store medication:**
- Keep out of the reach of children
- Store away from heat and direct light
- Do not store in the bathroom, near the kitchen sink, or in damp places. Heat or moisture may cause the medicine to break down

**How to take this medication:**
- Take on an empty stomach with a glass of water.
- The tablet may be crushed in applesauce
- Do not drink alcohol of any type, including wine or beer.
- Do not take antacids one hour before or after taking INH

**Tell your doctor, nurse or pharmacist if you take ANY other medication; especially medication for seizures.**

**Possible drug effects:**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiredness</td>
<td>Change in color of urine or stool</td>
</tr>
<tr>
<td>Weakness</td>
<td>Sore muscles</td>
</tr>
<tr>
<td>Fever</td>
<td>Tingling or numbness of fingers or toes</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>Vision changes</td>
</tr>
<tr>
<td>Nausea</td>
<td>Rash</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Weight loss</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Yellow skin or eyes</td>
</tr>
</tbody>
</table>

The information on the action and possible side effects of this medication prescribed by the doctor has been explained to me and I understand. I will call the doctor or nurse if I have any questions or symptoms. If you experience any adverse effects from this medication, stop taking the medication immediately and notify your physician and/or your medical provider. Seek emergency help if you have any signs of an allergic reaction: hives, difficulty breathing, and swelling of the face, lips, tongue, or throat.

Name: ___________________ Date: ___________ Witness: ___________________
What Should I Avoid While Taking Isoniazid?

Avoid alcohol while taking isoniazid. Alcohol will increase the risk of damage to the liver during treatment with this medication.

Use caution with the foods listed below. They can interact with isoniazid and cause a reaction that includes a severe headache, large pupils, neck stiffness, nausea, vomiting, diarrhea, flushing, sweating, itching, irregular heartbeats, and chest pain. A reaction will not necessarily occur, but eat these foods with caution until you know if you will react to them. Call your doctor immediately if you experience any of these symptoms.

Eat the following foods with caution:

- Cheeses, including American, Blue, Boursault, Brick, Brie, Camembert, Cheddar, Emmenthaler, Gruyere, Mozzarella, Parmesan, Romano, Roquefort, Stilton, and Swiss;
- Sour cream and yogurt;
- Beef or chicken liver, fish, meats prepared with tenderizer, bologna, pepperoni, salami, summer sausage, game meat, meat extracts, caviar, dried fish, herring, shrimp paste, and tuna;
- Avocados, bananas, figs, raisins, and sauerkraut;
- Soy sauce, miso soup, bean curd, and fava beans;
- Yeast extracts;
- Ginseng;
- Chocolate;
- Caffeine (coffee, tea, cola, etc.); and
- Beer (alcoholic and nonalcoholic), red wine (especially Chianti), sherry, vermouth, and other distilled spirits.
Medication Fact Sheet – Rifampin

It is important to take this medication for the full time of treatment, even if you begin to feel better after a few weeks. It is important you do not miss any doses. If you do miss a dose, take it as soon as possible. However, if it is almost time for your next dose, skip the missed dose and go back to your regular schedule. DO NOT double dose.

To store medication:
- Keep out of reach of children
- Store away from heat and direct light
- Do not store in the bathroom, near the kitchen sink, or in damp places. Heat or moisture may cause the medicine to break down.

How to take this medication:
- Take on an empty stomach with a glass of water
- If stomach irritation occurs, take with food

This drug will turn your urine, stool, sputum, and tears orange and can stain contact lenses. Tell your doctor, nurse, or pharmacist if you are taking ANY medications, even drugs you can buy without a prescription. In particular tell them if you take birth control pills, Coumadin, warfarin, theophylline, methadone, Dilantin, digoxin, or medicine for HIV infection, seizures or heart problems.

Possible drug effects:

<table>
<thead>
<tr>
<th>Effect</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiredness</td>
<td>Rash</td>
</tr>
<tr>
<td>Itching</td>
<td>Stomach pain</td>
</tr>
<tr>
<td>Sore muscles</td>
<td>Fever</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Weight loss</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Yellow skin or eyes</td>
</tr>
<tr>
<td>Chills</td>
<td>Bone or muscle pain</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>Nausea</td>
</tr>
</tbody>
</table>

If you experience any adverse effects from this medication, stop taking the medication immediately and notify your physician and/or your medical provider. Seek emergency help if you have any signs of an allergic reaction: hives, difficulty breathing, and swelling of the face, lips, tongue, or throat.

The possible side effects of this medication prescribed by the doctor, has been explained to me and I understand. I will call the doctor or nurse immediately if I have any questions or symptoms.

Name: ___________________________ Date: ___________ Witness: ___________________________
Medication Fact Sheet – Pyrazinamide (PZA)

It is important to take this medication for the full time of treatment, even if you begin to feel better after a few weeks. It is important that you do not miss any doses. If you do miss a dose, take it as soon as possible. However, if it is almost time for your next dose, skip the missed dose and go back to your regular schedule. **DO NOT** double dose.

**To store medication:**

- Keep out of the reach of children
- Store away from heat and direct light
- Do not store in the bathroom, near the kitchen sink, or in damp places. Heat or moisture may cause the medicine to break down.

**How to take this medication:**

- It is okay to take PZA with food

Tell your doctor, nurse, or pharmacist if you are taking ANY medication, even drugs you can buy without a prescription. If you are diabetic, check with your doctor before changing your diet or dose of medication for diabetes. PZA may cause false positive results with urine ketone test.

**Possible drug effects:**

<table>
<thead>
<tr>
<th>Tiredness</th>
<th>Weakness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>Nausea</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Weight loss</td>
</tr>
<tr>
<td>Yellow skin or eyes</td>
<td>Change on color of urine or stool</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>Joint pains, especially in the big toe</td>
</tr>
</tbody>
</table>

If you experience any adverse effects from this medication, stop taking the medication immediately and notify your physician and/or your medical provider. Seek emergency help if you have any signs of an allergic reaction: hives, difficulty breathing, and swelling of the face, lips, tongue, or throat.

The possible side effects of this medication prescribed by the doctor, has been explained to me and I understand. I will call the doctor or nurse immediately if I have any questions or symptoms.

Name: ___________________________ Date: ___________ Witness: ___________________________
Medication Fact Sheet – Ethambutol (Myambutol)

It is important to take this medication for the full time of treatment, even if you begin to feel better after a few weeks. It is important that you do not miss any doses. If you do miss a dose, take it as soon as possible. However, if it is almost time for your next dose, skip the missed dose and go back to your regular schedule. **DO NOT** double dose.

**To store medication:**
- Keep out of the reach of children
- Store away from heat and direct light
- Do not store in the bathroom, near the kitchen sink, or in damp places. Heat or moisture may cause the medicine to break down.

**How to take this medication:**
- It is okay to take Ethambutol with food

Tell your doctor, nurse, or pharmacist if you take ANY other medication; especially medication for seizures.

**Possible drug effects:**
- Weakness
- Stomach pain
- Vision changes
- Nausea
- Eye pain
- Vomiting
- Nervousness
- Yellow skin or eyes
- Dizziness
- Change in color of urine or stool
- Headache
- Light headedness
- Loss of appetite
- Joint pains
- Weight loss

If you experience any adverse effects from this medication, stop taking the medication immediately and notify your physician and/or your medical provider. Seek emergency help if you have any signs of an allergic reaction: hives, difficulty breathing, and swelling of the face, lips, tongue, or throat.

The possible side effects of this medication prescribed by the doctor, has been explained to me and I understand. I will call the doctor or nurse immediately if I have any questions or symptoms.

Name: __________________________ Date: ____________ Witness: __________________________
Medication Fact Sheet – Pyriodoxine (B6)

Other NAMES: Vitamin B6
It is important to take this medication for the full time of treatment, even if you begin to feel better after a few weeks. It is important that your do not miss any doses. If you do miss a dose, take it as soon as possible. However, if it is almost time for your next dose, skip the missed dose and go back to your regular schedule. DO NOT double dose.

To store medication:
- Keep out of reach of children
- Store away from heat and direct light
- Store in a cool (15 – 30°C) dry place in a tightly-closed container

How to take this medication:
- Take with a glass of water
- The tablet may be crushed in applesauce
- Some medicines or medical conditions may interact or decrease the effectiveness of some drugs with this medicine
- Do not take large doses of vitamins (megadoses or megavitamin therapy) while taking this medicine
- If stomach irritation occurs take with food

Tell your doctor, nurse or pharmacist if you take ANY other medication; especially medication for Parkinson’s disease, seizures and or arthritis.

Possible side effects of medication:

<table>
<thead>
<tr>
<th>Effect</th>
<th>Side Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea</td>
<td>Itching</td>
</tr>
<tr>
<td>Stomach Upset</td>
<td>Tingling or numbness of the skin</td>
</tr>
<tr>
<td>Headache</td>
<td>Swelling</td>
</tr>
<tr>
<td>Drowsiness</td>
<td>Dizziness</td>
</tr>
<tr>
<td>Rash</td>
<td>Trouble breathing</td>
</tr>
</tbody>
</table>

If you experience any adverse effects from this medication, stop taking the medication immediately and notify your physician and/or your medical provider. Seek emergency help if you have any signs of an allergic reaction: hives, difficulty breathing, and swelling of the face, lips, tongue, or throat.

The possible side effects of this medication prescribed by the doctor, has been explained to me and I understand. I will call the doctor or nurse immediately if I have any questions or symptoms.

Name: ___________________________ Date: ________________ Witness: ___________________________
Medication Fact Sheet – Rifapentine

It is important to take this medication for the full time of treatment, even if you begin to feel better after a few weeks. It is important that you do not miss any doses. If you do miss a dose, take it as soon as possible. However, if it is almost time for your next dose, skip the missed dose and go back to your regular schedule. **DO NOT** double dose.

**To store medication:**
- Keep out of the reach of children
- Store away from heat and direct light
- Don not store in the bathroom, near the kitchen sink, or in damp places. Heat or moisture may cause the medicine to break down

**How to take this medication:**
- Take on an empty stomach with a glass of water
- If stomach irritation occurs, take with food

This drug will turn your urine, stool, sputum, and tears orange and can stain contact lenses and dentures. Tell your doctor, nurse, or pharmacist if you are taking ANY medications, even drugs you can buy without a prescription. In particular, tell them if you take birth control pills, Coumadin, Warfarin, Theophylline, Methadone, Dilantin, Digoxin, or medicine for HIV, seizures, or heart conditions, and or arthritis. Before taking Rifapentine, tell your doctor if you have porphyria.

**Possible side effects of medication:**

- Tiredness
- Rash
- Itching
- Stomach pain
- Sore muscles
- Fever
- Vomiting
- Weight loss
- Diarrhea
- Yellow skin r eyes
- Chills
- Bone or muscle pain
- Loss of appetite
- Nausea
- Pale Skin
- Easy Bleeding or Bruising

If you experience any adverse effects from this medication, stop taking the medication immediately and notify your physician and/or your medical provider. Seek emergency help if you have any signs of an allergic reaction: hives, difficulty breathing, and swelling of the face, lips, tongue, or throat.

The possible side effects of this medication prescribed by the doctor, has been explained to me and I understand. I will call the doctor or nurse immediately if I have any questions or symptoms.

Name: ___________________________ Date: ___________________________ Witness: ___________________________
Medication Fact Sheet – Levofloxacin

It is important to take this medication for the full time of treatment. It is important that you do not miss any doses. If you do miss a dose, take it as soon as possible. However, if it is almost time for your next dose, skip the missed dose and go back to your regular schedule. DO NOT double dose.

To store medication:

- Keep out of the reach of children
- Store at room temperature
- Do not store in the bathroom, near the kitchen sink or in damp places

How to take this medication:

- Do not take within two hours of ingestion of milk-based products, antacids, or taking iron, magnesium, calcium, zinc, vitamins, didanosine, sucralfate.
- Avoid caffeinated foods and beverages
- May take with food
- Drink plenty of beverages
- May cause sun sensitivity; use sun screen

Tell your doctor if you have any renal diseases.

Possible drug effects:

- Pain, swelling, or tearing of the tendon (such as the back of your ankle, elbow), muscle or joint pain
- Rashes or hives
- Bruising or blistering
- Trouble breathing or tightness in your chest
- Diarrhea
- Yellow skin or eyes
- Anxiety, confusion, or dizziness

If you experience any adverse effects from this medication, stop taking the medication immediately and notify your physician and/or your medical provider. Seek emergency help if you have any signs of an allergic reaction: hives, difficulty breathing, and swelling of the face, lips, tongue, or throat.

The possible side effects of this medication prescribed by the doctor, has been explained to me and I understand. I will call the doctor or nurse immediately if I have any questions or symptoms.
Medication Fact Sheet – Streptomycin

It is important to take this medication for the full time of treatment. It is important that you do not miss any doses. If you do miss a dose, take it as soon as possible. However, if it is almost time for your next dose, skip the missed dose and go back to your regular schedule. **DO NOT** double dose.

**To store medication:**

- Store in refrigerator

Injection sites should be rotated for maximum absorption

**Possible drug effects:**

- Problems with hearing, dizziness, or balance
- Rash or swelling of your face
- Trouble breathing
- Decreased urination
- Watery or bloody diarrhea
- Increased swelling, pain, or redness at injection site
- Muscle twitching or weakness

If you experience any adverse effects from this medication, stop taking the medication immediately and notify your physician and/or your medical provider. Seek emergency help if you have any signs of an allergic reaction: hives, difficulty breathing, and swelling of the face, lips, tongue, or throat.

The possible side effects of this medication prescribed by the doctor, has been explained to me and I understand. I will call the doctor or nurse immediately if I have any questions or symptoms.

Name: ____________________________ Date: ______________ Witness: ____________________________
TUBERCULOSIS ELIMINATION FACT SHEET

Reporting

Active tuberculosis disease or disease suspect – Report within 24 hours to your local public health agency or to the Missouri Department of Health and Senior Services at (573) 751-6113 or (866) 628-9891. Tuberculosis infection/Other mycobacterial diseases – Report within three days to your local public health agency or the Missouri Department of Health and Senior Services at (573) 751-6113 or (866) 628-9891.

PROMPT REPORTING TRIGGERS THE FOLLOWING SERVICES AS NEEDED AT NO COST TO THE PATIENT:

Medications

Routine anti-tuberculosis antibiotics including Isoniazid, Rifampin, Pyrazinamide, Ethambutol, Streptomycin, Rifapentine, and Vitamin B6 are provided through the local public health agency via contract with Red Cross Pharmacy. Other second-line drugs may also be available.

Lab Services

The state tuberculosis laboratory is in Jefferson City, Missouri and is one of the best TB labs in the country. Diagnostic and routine laboratory services may be available through the patient’s local public health agency, (e.g. liver enzymes, PPDs).

Contact Investigations and Case Management

Local public health agencies have community health nurses trained to conduct contact investigations of communicable disease, including tuberculosis. A report of a suspect TB case will trigger a contact investigation and 3-month follow-up.

Tuberculosis disease and infection cases may be managed through local public health agency. Management includes monthly physical assessment, liver enzyme monitoring, sputum sampling, directly observed therapy (the standard of care for all TB cases), and patient education.

Consultation

The Tuberculosis Elimination Program employs staff that oversees case management of all active disease cases and suspects in Missouri. They are current on tuberculosis prevention, treatment and control and are available for consultation as needed. Medical consultation is available through the TB Elimination Program nurse.
Other Services

Diagnostic Services Program pays for office visits and chest x-rays for those TB infection and disease patients with financial barriers to health care.

Incentive Program helps ensure compliance with low-income patients. Incentives include expenses such as cab fare or bus tokens. Incentive funds are available through your local public health agency.

Texas Center for Infectious Disease – Texas Center for Infectious Disease maintains a state-of-the-art care and isolation of tuberculosis patients. Texas Center for Infectious Disease is located in San Antonio, Texas. This facility only receives those TB patients that are most difficult to treat or are non-compliant with their treatment.

Resources – the Tuberculosis Elimination Program houses a library with the latest treatment information for tuberculosis and other mycobacterial diseases. CDC, ALA, American Thoracic Society and other publications, videotapes and guidelines regarding the treatment of TB disease and infection are available upon request.

We view TB Elimination as a team approach. One person cannot do it alone, but one person can make a difference. We need your help if we are to reach our goal of eliminating TB in Missouri.

TUBERCULOSIS ELIMINATION PROGRAM

PHONE: (573) 751-6113
OR
(866) 628-9891
FAX: (573) 526-0234
The following forms can be found in the Missouri Department of Health and Senior Services Tuberculosis Case Management Manual Section Appendices/"Sample Forms"


The TB Elimination Program no longer provides medications for LTBI if the patient is covered by insurance, except for the following individuals:

- Those with evidence of tuberculosis infection who are close contacts (high or medium risk) to a current active tuberculosis disease case
- Those who are refugees with temporary Medicaid

The above exceptions may change at the discrimination of the TB Elimination Program. If you have a patient that is insured and you are unsure if they qualify to obtain medications, please notify the TB Elimination Program, 573-751-6113.

**Required Forms:**

**LTBI:**

- Tuberculin Testing Record (TBC-4) preferably or Disease Case Report (CD-1). TB Infection is reportable to the TB Elimination Program, so this should be faxed to the State TB nurse, regardless where the patient is receiving their medications.
- TB Signs and Symptoms Checklist (Review with the patient). If the patient is having any signs or symptoms of tuberculosis collect sputum. (See the sputum collection instruction and algorithm in Section 4, TB Disease). Do not start patient on treatment for LTBI until all cultures (not smears) are negative.
- LTBI Medication Authorization (MO 580-3050). This completed form should be faxed to the State TB nurse for patients that qualify for obtaining medications thru the TB Elimination Program. A copy of the completed TBC-4 preferably or a completed CD-1, current CXR/CT chest report, and a copy of the prescriptions need to be faxed with the completed LTBI Medication Authorization form to the State TB nurse.
- INH/Rifapentine (12 Dose/3HP) Tuberculosis Medication Eligibility/Authorization (MO 580-3025). This form should be completed for patients that are prescribed the 12 dose medication regimen only. (This form takes the place of the LTBI Medication Authorization form). A copy of the completed TBC-4 preferably or a completed CD-1, current CXR/CT chest report, and a copy of the prescriptions must be faxed along with the completed authorization form to the State TB nurse. This regimen must be given by Directly Observed Therapy (DOT) and the LPHA nurse must fax a copy of the completed 3HP Regimen Form (MO 580-3130) to the State TB nurse weekly.
• Document to Decline Treatment of Latent Tuberculosis Infection (LTBI). This signed document must accompany a completed TBC-4 preferably or CD-1 and be faxed to the State TB Nurse if not being entered into WebSurv by the LPHA.

TB Disease:

• CD-1. Notify the State TB nurse and fax a copy of the completed form as soon as you have been notified.
• TB Signs and Symptoms Checklist (Review with the patient).
• TB History (TBC-10, put the patient’s current weight on the form. Fax the completed form to the State TB Nurse as soon as the patient interview has been completed.
• Tuberculosis (TB) Patient Responsibilities Notification (located in the TB Case Management Manual, Section 7, Court Force Handbook http://health.mo.gov/living/healthcondiseases/communicable/tuberculosis/tbmanual/index.php). The LPHA nurse should go over this form with the patient and the patient should sign and date it, along with the LPHA nurse witnessing the patient’s signature. Give a copy of the signed form to the patient and keep the original in the patient’s chart.
• TB Worksheet for Contacts of Newly Diagnosed Cases (TBC-13). Fax the completed form to the TB Elimination Program at the beginning of the contact investigation and at completion, as well as when there are new contacts added to the form.
• TB Medication Request Form (TBC-8). This must be faxed along with a copy of the prescriptions to the state contract pharmacy. (Verify with the State TB Nurse that the prescriptions are correct prior to faxing the medication request to the pharmacy).
• TB Medication Record (TBC-16). This must be faxed at the end of each completed month of medication to the State TB Nurse.
• Cohort Presentation (MO 580-2826) (Print this form as soon as you receive a case and start completing it. The cohort is done bi-annually. You will receive a letter from the TB Elimination Program if you have a case to be cohorted. This form will need to be completed and a copy faxed upon request to the TB Elimination Program for the bi-annual cohort.

Required Documentation:

• CXR/CT scan report – fax to the State TB nurse
• Lab results – fax a copy of all labs, such as sputum smears/cultures, Liver function results (LFT), TST/IGRA (T Spot or Quantiferon Gold); biopsy report, etc. to the State TB Nurse
• Copy of Prescriptions (TB medications) must be faxed to the State TB Nurse. Resubmit if there are any medication changes.
• Copy of the History/Physical, emergency room note, Pulmonology or Infectious Disease Consult note, if patient was hospitalized or seen by a physician. Fax a copy to the State TB nurse.

The above documentation must be faxed to your state TB Elimination Program nurse.
Traci Hadley: (417) 629-3477 for regions A, D, E, G, H

Teresa Wortmann: (573) 526-0234 for regions B, C, F, I, and for all Multi-Drug Resistant (MDR) cases

**Additional Forms (keep in patient’s record):**

- TBC-8 (TB Medication Request Form) If patient has private insurance, Medicaid or Medicare, please complete the insurance portion on the form.
- TBC-DSP: Only completed if patient has no insurance or financial varies to health care exist. Please complete and fax to Diana Winder at (573) 526-0234. Liver Function Tests (LFTs) must be approved by your state TB elimination program nurse and are only approved for patients currently taking TB medications and having symptoms of possible hepatotoxicity. Please contact your state TB elimination program nurse for approval of LFTs for any other medical issues.
- TBC-a5A (TB Case Register Card) Checklist for Active Tuberculosis (very helpful when following an active TB case)
- Progress Notes
- Tuberculosis Signs and Symptoms Checklist (All LTBI and TB Disease cases need to be assessed for signs and symptoms)

**Helpful TB web addresses:**

- Centers for Disease Control and Prevention/Tuberculosis  
- Centers for Disease Control and Prevention/5th edition of the Core Curriculum on Tuberculosis: What the Clinician Should Know  
  [https://www.cdc.gov/tb/education/corecurr/pdf/corecurr_all.pdf](https://www.cdc.gov/tb/education/corecurr/pdf/corecurr_all.pdf)
- MMWR: Treatment of Tuberculosis, June 20, 2003/Vol. 52/No. RR-11  
URINE COLOR CHART

DRAW LFTS
Checklist for Latent TB Infection Cases

INITIAL WORKUP:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>NOT APPLICABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Front side TBC-4 completed and entered in WebSurv</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Release of information signed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal/Written educational material given in client’s primary language, if applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest x-ray results obtained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB signs/symptoms checklist reviewed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver function tests results obtained, if indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescriptions obtained, faxed to the Contract Pharmacy and mailed original</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Front side TBC-4 sent to DHSS TB Program and entered into WebSurv</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DURING TREATMENT:

<table>
<thead>
<tr>
<th>Month 1</th>
<th>Month 2</th>
<th>Month 3</th>
<th>Month 4</th>
<th>Month 5</th>
<th>Month 6</th>
<th>Month 7</th>
<th>Month 8</th>
<th>Month 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication dispensed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>TBC-4 Checklist completed</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LFT if indicated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entered visit in WebSurv Encounter page</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

COMPLETION OF TREATMENT:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBC-4 completed</td>
<td></td>
</tr>
<tr>
<td>Completion letter to client</td>
<td></td>
</tr>
<tr>
<td>TBC-4 sent to DHSS TB Program and entered in Websurv</td>
<td></td>
</tr>
</tbody>
</table>
Tuberculosis Signs and Symptoms Checklist

Client Name: _____________________________ Date: __________________

1. Have you ever had a positive skin or blood test for TB? Yes No
   If yes have you received treatment? Yes No
   When? ________________
   Is there written documentation? Yes No
2. Do you smoke? Yes No
3. Do you have a cough? Yes No
4. Do you cough up anything? Yes No
5. Do you cough up blood? Yes No
6. Have you lost weight? Yes No
7. Has your appetite decreased? Yes No
8. Do you have fever or chills? Yes No
9. Do you have night sweats? Yes No
10. Do you feel unusually tired or weak? Yes No
11. Do you have chest pains? Yes No
12. Have you been in close contact with someone who has TB? Yes No
13. Have you taken prednisone or steroids recently? Yes No
14. Are you taking any medications for arthritis? Yes No
15. Have you recently been treated for cancer? Yes No
16. Do you drink alcohol? Yes No
17. Are you pregnant? Yes No
18. Are you foreign born? Yes No
   If so, what country were you born in? ________________
19. How long have you lived in the United States? ________________

Comments: ___________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Nurse Signature: _____________________________ Date: __________________

Missouri Department of Health and Senior Services
Tuberculosis Case Management Manual
## Checklist for Active Disease Cases

<table>
<thead>
<tr>
<th>INITIAL WORKUP</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cd-1 Completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct patient interview</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete TB History (TBC-10) Form</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CD-1 &amp; TB History Form faxed/mailed to state TB nurse</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Isolate per the CDC recommendations (CDC Core Curriculum on Tuberculosis-Infection Control)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact/source case investigation initiated using the Contact Worksheet (TBC-13)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient education provided on isolation procedures as needed, in client’s primary language and documented</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission note completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sputum sent to the State Public Health Laboratory for culture &amp; sensitivity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic services arranged, if needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV testing offered</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline eye and color vision exam; LFT if applicable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescriptions obtained and faxed to State Contract Pharmacy, along with the TB Medication Request (TBC-8)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOT initiated using the TB Medication Record (TBC-16)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Worksheet (TBC-13) faxed to state TB nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DURING TREATMENT:</th>
<th>Month 1</th>
<th>Month 2</th>
<th>Month 3</th>
<th>Month 4</th>
<th>Month 5</th>
<th>Month 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess &amp; document on TBC-1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LFT, if indicated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOT (# of doses this month)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sputum submitted</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB Medication Record (TBC-16) sent to state TB nurse monthly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COMPLETION OF TREATMENT:</th>
<th>YES</th>
<th>NO</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of therapy documented (including # of doses received)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COMPLETION LETTER TO CLIENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State TB nurse notified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLASS</td>
<td>TYPE</td>
<td>CLASSIFICATION</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>No TB Exposure</td>
<td>No history of exposure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Infected</td>
<td>Negative reaction to TB skin test</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>TB Exposure</td>
<td>History of exposure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No evidence of infection</td>
<td>Negative reaction to TB skin test</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>TB Infection</td>
<td>Positive reaction to TB skin test</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No Disease</td>
<td>Negative bacteriological studies (if done)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No clinical, bacteriological, or radiographic evidence of active TB</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>TB, clinically active</td>
<td>M. tuberculosis cultured (if done)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinical, bacteriological, or radiographic evidence of TB</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>TB</td>
<td>History of episode(s) of TB</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Abnormal but stable radiographic findings</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Positive reaction to TB skin test</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Negative bacteriological studies (if done)</td>
<td></td>
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<td></td>
<td></td>
<td>AND</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No clinical radiographic evidence of current disease</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>TB Suspected</td>
<td>Diagnosis pending</td>
<td></td>
</tr>
</tbody>
</table>

Comments:
- CDC counts clinical cases of tuberculosis as a case if the criteria are met.
- **Tuberculosis disease is currently not reportable to CDC through MOHSIS**

**Case/Contact Follow up and Control Measures:**
- A person suspected of having tuberculosis of the throat or lungs should be isolated either in their home or in the hospital until they have met the following criteria:
  - 2 weeks of treatment,
  - 3 negative smears,
  - and are clinically improving
ANNUAL STATEMENT FOR TUBERCULIN REACTORS

NAME: ________________________________________________

DATE OF BIRTH: _________________________________________

SIGN/SYMPTOMS SCREENING (Yes/No):

[ ] Cough lasting longer than three (3) weeks
[ ] Unexplained fever
[ ] Night sweats
[ ] Unexplained weight loss
[ ] Coughing up blood
[ ] Chest pain

IF NONE OF THESE SYMPTOMS ARE PRESENT, A CHEST X-RAY IS NOT NECESSARY.

Nurse/Physician ______________________________________ Date __________

[ ] I am tuberculin positive with negative CXR. I have had the recommended course of treatment for Latent Tuberculosis Infection (LTBI).

[ ] I am tuberculin positive. I have completed the recommended course of treatment for Tuberculosis Disease.

[ ] I am tuberculin positive and have not completed the recommended course of treatment.

If I develop any of the above symptoms, I agree to seek immediate medical attention.

Patient ______________________________________ Date __________