	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Subsection: Table of Contents	Page 1 of 2

APPENDICES

1.0 Missouri Statutes and Regulations Concerning Tuberculosis

- 1.01 [Missouri Revised Statutes](#)
- 1.02 [Missouri Regulations](#)

2.0 Educational Materials


- 2.01 [Ordering Educational Materials](#)
- 2.02 [Medication Fact Sheet: Isoniazid \(INH\)](#)
- 2.03 [Medication Fact Sheet: Rifampin \(RIF\)](#)
- 2.04 [Medication Fact Sheet: Pyrazinamide \(PZA\)](#)
- 2.05 [Medication Fact Sheet: Ethambutol \(Myambutol\) \(ETH\)](#)
- 2.06 [Medication Fact Sheet: Priodoxine \(B-6\)](#)
- 2.07 [Medication Fact Sheet: Rifapentine \(RPT\)](#)
- 2.08 [Medication Fact Sheet: Levofloxacin](#)
- 2.09 [Medication Fact Sheet: Streptomycin](#)
- 2.10 [Tuberculosis Control Fact Sheet](#)

3.0 Other Resources

- 3.01 [TB Forms and Documentation](#)
- 3.02 [Urine Chart](#)
- 3.03 [Checklist for Latent TB Infection](#)
- 3.04 [Tuberculosis Signs/Symptoms Checklist](#)
- 3.05 [Checklist for Active TB Disease](#)
- 3.06 [Case Classification](#)
- 3.07 [Diagnostic Services Provider Listing](#)


4.0 Sample Forms *(click on link in each title)*

- 4.01 [Annual Statement for Tuberculin Reactors](#)
- 4.02 [CD-1 Disease Case Report](#)
- 4.03 [Isoniazid/Rifapentine \(12-Dose\) Tuberculosis Medication Eligibility/Authorization](#)
- 4.04 [TBC-1 Tuberculosis Drug Monitoring](#)
- 4.05 [TBC-2 Document to Decline Treatment of Latent TB Infection \(LTBI\)](#)
- 4.06 [LTBI Medication Authorization Form](#)
- 4.07 [TBC-4 Tuberculin Testing Record](#)
- 4.08 [TBC-8 Medication Request Form](#)
- 4.09 [TBC-10 Tuberculosis History](#)
- 4.10 [TBC-13 TB Worksheet for Contacts of Newly Diagnosed Cases](#)

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Subsection: Table of Contents	Page 2 of 2

- 4.11 [TBC-15A TB Case Register Card](#)
- 4.12 [TBC-16 TB Medication Record](#)
- 4.13 [TBC-18 TB Skin Test Record](#)
- 4.14 [TBC-19 Certificate of Completion of TB Treatment](#)
- 4.15 [TBC-DSP Diagnostic Services Eligibility authorization Form](#)
- 4.16 [Cohort Presentation Form](#)
- 4.17 [Progress Notes](#)
- 4.18 [TB Risk Assessment Form](#)
- 4.19 [3 HP Regimen Form](#)

 [Back to Top](#)

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Appendix: 1.01 Missouri Statutes and Regulations Concerning Tuberculosis	Page 1 of 2

Missouri Statutes and Regulations Concerning Tuberculosis

Click on the link after the title of the statute to access the complete text from the *Revised Statutes 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 be 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>

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Appendix: 1.02 Missouri Statutes and Regulations Concerning Tuberculosis	Page 2 of 2

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

<http://www.sos.mo.gov/cmsimages/adrules/csr/current/19csr/19c20-20.pdf>

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

19CSR 30-62.122 Medical Examination Reports

<http://s1.sos.mo.gov/cmsimages/adrules/csr/current/19csr/19c30-61.pdf>



[Back to Top](#)

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Subsection: 2.01 Educational Materials	Page 1 of 1

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://www.cdc.gov/pubs/CDCInfoOnDemand.aspx>

 [Back to Top](#)

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Subsection: 2.02 Medication Fact Sheet – Isoniazid (INH)	Page 1 of 2

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
- 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.
- 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:

Tiredness	Change in color of urine or stool
Weakness	Sore muscles
Fever	Tingling or numbness of fingers or toes
Loss of appetite	Vision changes
Nausea	Rash
Vomiting	Weight loss
Diarrhea	Yellow skin or eyes

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: _____

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Subsection: 2.02 Medication Fact Sheet – Isoniazid (INH)	Page 2 of 2


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

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Subsection: 2.03 Medication Fact Sheet – Rifampin (RIF)	Page 1 of 1

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
- 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. 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:

- | | |
|------------------|---------------------|
| Tiredness | Rash |
| Itching | Stomach pain |
| Sore muscles | Fever |
| Vomiting | Weight loss |
| Diarrhea | Yellow skin or eyes |
| Chills | Bone or muscle pain |
| Loss of appetite | Nausea |

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: _____

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Subsection: 2.04 Medication Fact Sheet – Pyrazinamide (PZA)	Page 1 of 1

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:

Tiredness	Weakness
Fever	Nausea
Vomiting	Weight loss
Yellow skin or eyes	Change on color of urine or stool
Loss of appetite	Joint pains, especially in the big toe

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: _____

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Subsection: 2.05 Medication Fact Sheet – Ethambutol (Myambutol)	Page 1 of 1

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: _____

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Subsection: 2.06 Medication Fact Sheet – Pyridoxine (B6)	Page 1 of 1

Medication Fact Sheet – Pyridoxine (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 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
- 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:

- | | |
|---------------|----------------------------------|
| Nausea | Itching |
| Stomach Upset | Tingling or numbness of the skin |
| Headache | Swelling |
| Drowsiness | Dizziness |
| Rash | Trouble breathing |

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: _____

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Subsection: 2.07 Medication Fact Sheet – Rifapentine	Page 1 of 1

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: _____

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Subsection: 2.08 Medication Fact Sheet – Levofloxacin	Page 1 of 1

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.

Name: _____ Date: _____ Witness: _____

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Subsection: 2.09 Medication Fact Sheet – Streptomycin	Page 1 of 1

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: _____

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Subsection: 2.10 Tuberculosis Elimination Fact Sheet	Page 1 of 2

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.

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Subsection: 2.10 Tuberculosis Elimination Fact Sheet	Page 2 of 2

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

 [Back to Top](#)

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Appendix: 3.01 Tuberculosis Forms and Documentation	Page 1 of 3

Tuberculosis Forms and Documentation

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 Case Management manual can be found at:

<http://health.mo.gov/living/healthcondiseases/communicable/tuberculosis/tbmanual/index.php>

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 discretion 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.

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Appendix: 3.01 Tuberculosis Forms and Documentation	Page 2 of 3

- 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.

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Appendix: 3.01 Tuberculosis Forms and Documentation	Page 3 of 3

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
<http://www.cdc.gov/tb/>
- 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
- MMWR: Treatment of Tuberculosis, June 20, 2003/Vol. 52/No. RR-11
<http://www.cdc.gov/mmwr/PDF/rr/rr5211.pdf>

 [Back to Top](#)



Division of Community and Public Health

Section: Appendices

Revised June 2017

Appendix: 3.02 Urine Chart


Page 1 of 1



URINE COLOR CHART

DRAW LFTS

 [Back to Top](#)

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Appendix: 3.03 Checklist for Latent TB Infection Cases	Page 1 of 1

Checklist for Latent TB Infection Cases

INITIAL WORKUP:


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

DURING TREATMENT:

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9
Medication dispensed									
TBC-4 Checklist completed									
LFT if indicated									
Entered visit in WebSurv Encounter page									

COMPLETION OF TREATMENT:

	YES	NO
TBC-4 completed		
Completion letter to client		
TBC-4 sent to DHSS TB Program and entered in Websurv		

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Appendix: 3.04 Tuberculosis Signs/Symptoms Checklist	Page 1 of 1

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: _____



Division of Community and Public Health

Section: Appendices

Revised June 2017

Appendix: 3.05 Checklist for Active TB Disease

Page 1 of 1

Checklist for Active Disease Cases

INITIAL WORKUP	<i>YES</i>	<i>NO</i>	<i>N/A</i>	<i>Notes</i>		
Cd-1 Completed						
Conduct patient interview						
Complete TB History (TBC-10) Form						
CD-1 & TB History Form faxed/mailed to state TB nurse						
Isolate per the CDC recommendations (CDC Core Curriculum on Tuberculosis-Infection Control)						
Contact/source case investigation initiated using the Contact Worksheet (TBC-13)						
Patient education provided on isolation procedures as needed, in client's primary language and documented						
Admission note completed						
Sputum sent to the State Public Health Laboratory for culture & sensitivity						
Diagnostic services arranged, if needed						
HIV testing offered						
Baseline eye and color vision exam; LFT if applicable						
Prescriptions obtained and faxed to State Contract Pharmacy, along with the TB Medication Request (TBC-8)						
DOT initiated using the TB Medication Record (TBC-16)						
Contact Worksheet (TBC-13) faxed to state TB nurse						
DURING TREATMENT:	<i>Month 1</i>	<i>Month 2</i>	<i>Month 3</i>	<i>Month 4</i>	<i>Month 5</i>	<i>Month 6</i>
Assess & document on TBC-1						
LFT, if indicated						
DOT (# of doses this month)						
Sputum submitted						
TB Medication Record (TBC-16) sent to state TB nurse monthly						
COMPLETION OF TREATMENT:	<i>YES</i>	<i>NO</i>	<i>Notes</i>			
Completion of therapy documented (including # of doses received)						
COMPLETION LETTER TO CLIENT						
State TB nurse notified						



Division of Community and Public Health

Section: Appendices

Revised June 2017


Appendix: 3.06 Case Classification

Page 1 of 1

CLASS	TYPE	CLASSIFICATION
0	<ul style="list-style-type: none"> No TB Exposure Not Infected 	<ul style="list-style-type: none"> No history of exposure Negative reaction to TB skin test
1	<ul style="list-style-type: none"> TB Exposure No evidence of infection 	<ul style="list-style-type: none"> History of exposure Negative reaction to TB skin test
2	<ul style="list-style-type: none"> TB Infection No Disease 	<ul style="list-style-type: none"> Positive reaction to TB skin test Negative bacteriological studies (if done) No clinical, bacteriological, or radiographic evidence of active TB
3	<ul style="list-style-type: none"> TB, clinically active 	<ul style="list-style-type: none"> M. tuberculosis cultured (if done) Clinical, bacteriological, or radiographic evidence of TB
4	<ul style="list-style-type: none"> TB 	<ul style="list-style-type: none"> History of episode(s) of TB OR Abnormal but stable radiographic findings Positive reaction to TB skin test Negative bacteriological studies (if done) AND No clinical radiographic evidence of current disease
5	TB Suspected	<ul style="list-style-type: none"> Diagnosis pending
Comments: <ul style="list-style-type: none"> CDC counts clinical cases of tuberculosis as a case if the criteria are met. Tuberculosis disease is currently <u>not</u> 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

	Division of Community and Public Health	
	Section: Appendices	Revised June 2017
	Appendix: 4.01 Annual Statement for Tuberculin Reactors	Page 1 of 1

ANNUAL STATEMENT FOR TUBERCULIN REACTORS

NAME: _____

DATE OF BIRTH: _____

SIGNS/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