Sample Forms

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Sample Forms:
List & Description

The Bureau of Communicable Disease Control and Prevention uses the following forms:

CD-1 Disease Case Report: Used by any health care provider or laboratory to report reportable disease (**including tuberculosis infection and disease,** but not AIDS/HIV) according to RSMo 192.006 and 192.020; 19 CSR 20-20.020 and 19 CSR 20-080 (See Appendix 3).

TBC-1 Tuberculosis Drug Monitoring: Used to document monthly monitoring of persons on antituberculosis medications for **tuberculosis disease.** (For persons taking treatment for tuberculosis infection, see TBC-4.)

TBC-2 Form to Document Refusal of Isoniazid Infection Treatment of Tuberculosis: Used to inform the person of the benefits of taking treatment for tuberculosis infection, and to obtain their signature that they are refusing treatment. May encourage the person to think carefully about the consequences of refusal.

TBC-4 Tuberculin Testing Record: Used by local health departments to document and report to the Bureau of Communicable Disease Control and Prevention are the following:

Baseline assessment data for treatment
Completion of treatment
Consent for testing and contract to return for reading
Current tuberculin skin test result
Follow-up chest x-ray
History of past tuberculin tests and BCG vaccination
Monthly monitoring of treatment
Patient demographics and locating information
Reason for testing
Risk factors
Treatment recommendations

This form can also be used as a Treatment register and tickler file. (According RSMo 192.006 and 192.020; 19 CSR 20-20.020 and 19 CSR 20-080; local statutes and ordinances).

TBC-10 Tuberculosis History: Used to determine current status and previous history of persons with tuberculosis disease ONLY.

TBC-13 Tuberculosis Worksheet for Contacts of Newly Diagnosed Cases of Tuberculosis: Used to document the results of tuberculin skin tests of all

Identified contacts to tuberculosis disease. The form is to be completed by three months after the case is initially identified. A copy of the form is forwarded to the Bureau of Communicable Disease Control and Prevention through the district tuberculosis control nurse.

TBC-15A Tuberculosis Case Register Card: Used by the Bureau of Communicable Disease Control and Prevention Registrar to maintain current information on all tuberculosis disease patients in the Out state (non-metropolitan) areas. May be used by any LPHA as an aid to maintaining current information on their patients with tuberculosis disease in one central Location (i.e. a register).

TBC-18 Tuberculin Skin Test Record: Used by any health care provider to furnish a record for proof of tuberculin skin test results to persons who need such proof for employment or other purposes. There is space for up to seven (7) results, with type of test, dates given and read, agency, and provider signature.

OTHER SAMPLE FORMS

Annual Statement for Tuberculin Reactors
Checklist for Active Disease
Diagnostic Services Eligibility/Authorization
Medication Request Form
Signs/Symptoms Checklist (English)
Sings/Symptoms Checklist (Spanish)

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
Section for Communicable Disease Prevention
930 Wildwood Drive, P.O. Box 570, Jefferson City, MO 65102-0570
Telephone: (573) 751-6113 FAX: (573) 526-0235

DISEASE CASE REPORT

IF CONDITION IS SUSPECTED AS BEING RELATED TO A DELIBERATE ACT OR OUTBREAK, CALL THE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES 24 HOURS A DAY, 7 DAYS A WEEK AT 1-800-392-0272

FOR PUBLIC HEALTH AGENCY USE ONLY	
CONDITION I.D.	PARTY I.D.
OUTBREAK I.D.	DATE RECEIVED BY LPHA
JURISDICTION	

Patient Information

NAME (LAST, FIRST, M.I.)	PATIENT IDENTIFIER	DATE OF BIRTH	AGE	MARITAL STATUS	SEX
					☐ Male ☐ Female

PATIENT'S COUNTRY OF ORIGIN	DATE ARRIVED IN USA	OCCUPATION	RACE/ETHNICITY (CHECK ALL THAT APPLY)
			☐ AMERICAN INDIAN ☐ PACIFIC ISLANDER ☐ UNKNOWN ☐ ASIAN ☐ WHITE ☐ BLACK ☐ OTHER RACE – Specify:
HOME TELEPHONE	WORK TELEPHONE	PARENT OR GUARDIAN	HISPANIC: ☐ YES ☐ NO ☐ UNK

IS PERSON HOMELESS? ☐ YES	ADDRESS	CITY, STATE, ZIP CODE	COUNTY OF RESIDENCE

WAS PATIENT HOSPITALIZED? ☐ YES ☐ NO	IF YES, NAME OF HOSPITAL	HOSPITAL ADDRESS	CITY, STATE, ZIP CODE	HOSPITAL TELEPHONE

Reporter

REPORTER NAME (Form Completed By)	REPORTING FACILITY	REPORTER ADDRESS	CITY, STATE, ZIP CODE	REPORTER TELEPHONE

TYPE OF REPORTING FACILITY	DATE OF REPORT	PHYSICIAN/CLINIC NAME	PHYSICIAN/CLINIC TELEPHONE	HAS PATIENT BEEN NOTIFIED OF DIAGNOSIS/LAB RESULTS?
☐ PHYSICIAN ☐ OUTPATIENT CLINIC ☐ HOSPITAL ☐ LABORATORY ☐ SCHOOL ☐ OTHER:				☐ YES ☐ NO ☐ UNK
	PHYSICIAN/CLINIC ADDRESS		CITY, STATE, ZIP CODE	

Risk/Background Information

PREGNANT	OTHER ASSOCIATED CASES?	RECENT TRAVEL OUTSIDE OF IMMEDIATE AREA?		
☐ YES - DUE DATE: ☐ NO ☐ UNK	☐ YES ☐ NO ☐ UNK	☐ YES ☐ NO ☐ UNK	DATE OF DEPARTURE	DATE OF RETURN / TRAVEL LOCATION

CHECK BELOW IF PATIENT OR MEMBER OF PATIENT'S HOUSEHOLD (HHLD):	PATIENT YES	PATIENT NO	PATIENT UNK	HHLD MEMBER YES	HHLD MEMBER NO	HHLD MEMBER UNK	IF YES, PROVIDE BUSINESS NAME, ADDRESS AND TELEPHONE NUMBER
IS A FOOD HANDLER?	☐	☐	☐	☐	☐	☐	
ASSOCIATED WITH OR ATTENDS CHILD/ ADULT CARE CENTER?	☐	☐	☐	☐	☐	☐	
ASSOCIATED WITH OR RESIDENT OF NURSING HOME?	☐	☐	☐	☐	☐	☐	
ASSOCIATED WITH OR INMATE OF CORRECTIONAL FACILITY?	☐	☐	☐	☐	☐	☐	
ASSOCIATED WITH HOMELESS SHELTER?	☐	☐	☐	☐	☐	☐	
IS A STUDENT OR FACULTY/STAFF OF A SCHOOL?	☐	☐	☐	☐	☐	☐	
IS A HEALTH CARE WORKER?	☐	☐	☐	☐	☐	☐	
OTHER (specify):	☐	☐	☐	☐	☐	☐	

HAS PATIENT DONATED OR RECEIVED BLOOD OR TISSUE?	DATE DONATED	DATE RECEIVED	SPECIFY TYPE OF BLOOD OR TISSUE AND FACILITY NAME/ADDRESS
☐ ☐ ☐			

Disease

DISEASE/CONDITION NAME(S)	ONSET DATE(S)	DIAGNOSIS DATE(S)	SEVERITY OF VARICELLA	VACCINATION HISTORY FOR REPORTED CONDITION/DATES ☐ UNKNOWN
			☐ <50 lesions ☐ 50-249 lesions ☐ 250-500 lesions ☐ >500 lesions	

Symptoms

SYMPTOM	SYMPTOM SITE	ONSET DATE (MO/DAY/YR)	DURATION (DAYS)

DID PATIENT DIE OF THIS ILLNESS? ☐ YES ☐ NO - IF YES, GIVE DATE:

COMMENTS

Diagnostics

DO NOT COMPLETE DIAGNOSTICS IF LAB SLIP IS ATTACHED

RESULT DATE (MO/DAY/YR)	TYPE OF TEST	SPECIMEN TYPE/SOURCE	SPECIMEN DATE (MO/DAY/YR)	QUALITATIVE/QUANTITATIVE RESULTS	REFERENCE RANGE	LABORATORY NAME/ADDRESS (STREET, or RFD, CITY, STATE, ZIP CODE)	LIVER FUNCTION RESULTS
							ALT
							AST

Treatment

TYPE OF TREATMENT (MEDS) IF NOT TREATED, REASON	DOSAGE	TREATMENT START DATE (MO/DAY/YR)	TREATMENT END DATE (MO/DAY/YR)	TREATMENT DURATION (IN DAYS)	PREVIOUS MEDICATIONS USED FOR TREATMENT	PREVIOUS TREATMENT FACILITY	TELEPHONE NUMBER

NOTES FOR ALL RELEVANT SECTIONS

- For cases of varicella, complete only the data fields for the patient's: Name, Date of Birth, County of Residence, Date of Report, Other Associated Cases, Disease/Condition Name(s), Onset Date, Severity of Varicella, Vaccination History for Reported Condition/Dates, and Did Patient Die Of This Illness; if diagnostic test(s) were performed - provide Lab Slip.
- Do not use this form to report weekly aggregate influenza incidence.
- Risk factors, diagnostics, treatments, and symptoms shown below are examples. To see a list of communicable disease resources available online, go to http://www.dhss.mo.gov/CommunicableDisease/. For additional information or to report a case of a reportable disease/condition, you may also contact the Office of Surveillance at 1-866-629-9891.
- All dates must be in MONTH/DAY/YEAR (01/01/2005) format.
- To be complete, all addresses should include the city, state, and zip code.
- All telephone numbers should include the area code.

PATIENT INFORMATION

- Name: Provide the patient's full name, including the full first name.
- Patient Identifier: Provide patient's SSN, medical record, inmate, DCN, or other identifying number and indicate identifier provided.
- Age: If the patient is less than one year, provide patient age in months; or if less than one month, provide patient age in days.
- Race/ethnicity: Patient race/ethnicity is determined by the self-identification of each patient.
- Date arrived in USA: Do not complete this data field for those patients who were born in the United States as an American citizen.
- Address: If homeless, check the appropriate box and provide an address where the patient can be located (i.e., shelter, etc.).
- Patient hospitalized: Indicate if the patient was hospitalized due to the reported disease/condition.

REPORTER

- Reporter name (Form completed by): Provide the name of the individual who completed this form.
- Reporting facility: Provide the name of the facility where the Reporter is employed. Facilities include hospital, physician, local public health agency, etc.
- Date of report: Provide the date the form was submitted by the Reporter.

RISK/BACKGROUND INFORMATION

- Associated cases: Indicate if other cases (individuals with similar symptoms) are associated with the patient's disease/condition.
- Other risk/background information may include environmental exposure or exposure due to animals, recreation, and occupation.

DISEASE

- Disease name(s): Specify the disease(s)/condition(s) that is reported on this form, as listed in 19 CSR 20-20.020 Reporting Communicable, Environmental and Occupational Diseases – Sections (1) and (2).
- Onset date: Indicate the date when the symptoms started.
- Diagnosis date: Indicate the date when a physician diagnosed the disease/condition.
- Severity of varicella: Indicate the estimated number of skin lesions on the patient's total body surface.
- Vaccination history: Provide the vaccination history for the disease/condition, including vaccine type and manufacturer.

SYMPTOMS

- Symptom: Indicate the symptom(s) associated with the disease/condition. Symptoms may include jaundice, fever, headache, rash, lesion, discharge, etc.
- Onset date: Indicate the date when each symptom started.
- Pertinent information: Provide any additional symptoms-related comments. Attach additional sheets if more space is needed.

DIAGNOSTICS - Please attach a copy of all lab results. Do not complete this section if lab results are attached.

- Result date: Indicate the date that each laboratory result was reported, usually to the submitting physician, clinic, etc.
- Type of test: Indicate each type of test performed. Examples of tests are carboxyhemoglobin, chest x-ray, culture, EIA, gram stain, ICP/MS, PCR, RBC/Serum Cholinesterase, RPR, serum organochlorine panel, etc.
- Specimen type/source: Indicate the specimen type/source for each test. Examples of specimen types are blood, cerebrospinal fluid (CSF), hair, nails, smear, stool, urine, etc.
- Specimen date: Indicate the collection date for each specimen.
- Qualitative/quantitative results: Indicate the result for each test.
    - Examples of qualitative results are positive, reactive, negative, equivocal, undetectable, etc.
    - Examples of quantitative results are 1:16, 2.0 mm, 2000 IU/mL, 65 mcg/dL, 1.8 IV, 10 ppb, index value, etc.
    - Examples of quantitative results for tuberculosis when administering the Mantoux test - (PPD), indicate the diameter of the induration (i.e., 2 mm, 15 mm, etc.).
- Reference range: Indicate the reference range for each quantitative result. Examples of reference ranges are: <1:10, <600 IU/mL, 1:64, <10 mcg/dL, etc.
- Liver function results: ALT = alanine aminotransferase (SGPT); AST = aspartate aminostransferase (SGOT)

TREATMENT

- Type of treatment: Indicate the medication(s) and/or therapy(ies) prescribed for treatment of the disease(s)/condition(s).
    - Reasons for not treating include – but are not limited to – 'False Positive', 'Previously Treated', and 'Age'.
- Dosage: Indicate the number of units (i.e., 50, 500, etc.), measurement (i.e., cc, mg, etc.), and number of times taken each day and/or week for each medication.

Missouri Department of Health and Senior services
Tuberculosis Drug Monitoring

Patient Name			Local Public Health Agency
Date of Birth	Age	Med Start Date:	☐ Suspect ☐ TB Case ☐ MOTT
		Med Stop Date:	☐ Completed Treatment ☐ Moved ☐ Died ☐ Not TB ☐ Lost

Use new form when medications are changed

Date of Visit										
Date of Next Visit										
INH _____mg ☐ Daily ☐ 2x Week ☐ 3 x Week										
Rifampin_____mg ☐ Daily ☐ 2x Week ☐ 3 x Week										
Ethambutol_____mg ☐ Daily ☐ 2x Week ☐ 3 x Week										
PZA _____mg ☐ Daily ☐ 2x Week ☐ 3 x Week										
Vitamin B6_____mg ☐ Daily ☐ 2x Week ☐ 3 x Week										
Other _____mg ☐ Daily ☐ 2x Week ☐ 3 x Week										
Medication DOT: Y or N										
DOT Given By: _____ **Self Administered Meds: Y or N**	Baseline									
Sputum Collected: Y or N (date)										
Patients Weight:										
LFT Collected: Y or N (date)										
Chest X-ray Done: Y or N (date)										
Adverse Effects All Drugs	Fatigue, Weakness*									
	Fever*, Chills*									
	Loss of Appetite*									
	Nausea, Vomiting*									
	Jaundice									
	Dark Brown Urine									
	Rash, Itching*									
	Joint Pain									
INH	Peripheral Neuritis									
Ethambutol	Blurred Vision: Y or N									
	Decreased Red/Green Vision Y or N									
	Screen Vision: LT									
	RT									
Rifampin	Birth Control Pills Taken?									
Any Drug	Other Symptoms									
Nurses Signature										

Missouri Department of Health and Senior Services
Refusal of Tuberculosis Therapy

Documentation to Decline Treatment of Latent TB Infection (LTBI)

I have been identified as being infected with tuberculosis. I have had explained to me that I have a lifetime risk of developing tuberculosis disease. My physician has prescribed a course of treatment with Isoniazid (INH) or Rifampin. Treatment with this medication will prevent the disease in most individuals who complete a recommended course of treatment. The medication and nursing case management will be provided at no cost to me from the local health department.

Without treatment for LTBI, the risk of developing tuberculosis (TB) in the first year following infection is approximately 5%. If the medication is not taken, I have a 1 in 20 chance of developing active TB disease within the first year. After the first year, the risk of developing TB disease is less. For recently infected individuals and others at high risk for disease, that risk is greater than the risk associated with INH treatment.

I have read the information on this form about treatment for LTBI. I understand the benefits and risks of taking treatment. I have had an opportunity to ask questions.

The health department has offered to provide me with the medication and the nursing case management to decrease my risk for developing tuberculosis disease. However, I have chosen not to take the medication as recommended. If I should change my mind, I understand that the Health department will be available to advise me on this matter.

Name (Print)	Date of Birth
Address (Street, City, State, Zip)	County
Signature of person refusing LTBI treatment or parent, guardian or other authorized person	Date
Witness Name (Print)	
Witness Signature	Date

PREVENTIVE TREATMENT MONITORING **CONTINUATION**

Patients Name	**Date of Birth**	Note: **9** months of INH treatment is recommended for all infected persons

Encounter Date:												

Allergies:
☐ NKA ☐ Yes **List:**

Medications	**mg**												
B-6													
INH													
Rifampin													
Other													

Adverse Effects	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**
Fatigue, weakness												
Fever, chills												
Loss of Appetite												
Nausea												
Vomiting												
Jaundice												
Dark Brown Urine												
Rash												
Itching												
Joint Pain												
Numbness/Tingling												
Other												

Other Medications:

Liver Enzyme Collection Data	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**
ALT Results	ALT:	ALT:	ALT:	ALT:	ALT:	ALT:	ALT:	ALT:	ALT:	ALT:	ALT:	ALT:
AST Results	AST:	AST:	AST:	AST:	AST:	AST:	AST:	AST:	AST:	AST:	AST:	AST:

Next Encounter Date:												
Comments:												
Evaluator Name/Signature												

COMPLETION OF TREATMENT

Treatment stopped *(Month/Day/Year)*

Treatment Completed *(Month/Day/Year)*

Reason Treatment Stopped:

☐Completed Treatment
☐Death
☐Client Moved (Follow-up Unknown)
☐Client Chose to Stop
☐ Active TB Developed
☐ Adverse Effect of Medicine
☐ No Therapy Needed
☐ Patient Refuses Preventive Therapy
☐ Client is Lost to Follow-Up
☐ Provider Decision to Stop
☐ Physician Declined Preventive Therapy

Date:

Health Care Provider Signature:

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

TB MEDICATION REQUEST

☐ NEW ☐ REFILL

FOR NEW ORDERS CALL 800-392-5586 OR FAX 660-886-2121
PLEASE MAIL OR FAX REFILL REQUESTS

HEALTH UNIT

CLIENT INFORMATION

NAME	DATE OF BIRTH	WEIGHT
ADDRESS (STREET, CITY, ZIP CODE)	SOCIAL SECURITY #	

PRESCRIPTION INSURANCE INFORMATION (ATTACH COPY OF CARD AT BOTTOM OF PAGE IF AVAILABLE)

INSURANCE PLAN (ie: MEDICAID, BLUE CHOICE, PCS, UNITED HEALTHCARE)		CLIENT'S RELATIONSHIP TO CARDHOLDER (ie: SELF, SPOUSE, DEPENDENT)
CARDHOLDER ID #	GROUP #	CLIENT'S ID # (IF DIFFERENT THAN CARDHOLDER)

PHYSICIAN INFORMATION

NAME	TELEPHONE #
ADDRESS (STREET, CITY, STATE, ZIP CODE)	

ADDITIONAL MEDICATIONS BEING TAKEN	DRUG ALLERGIES

TOTAL DURATION OF THERAPY _____ MONTHS

MEDICATION ORDER

ITEM	RX NUMBER	ITEM	RX NUMBER

PERSON COMPLETING FORM

NAME	TELEPHONE #

ATTACH COPIES OF PRESCRIPTION IF AVAILABLE

FAX FORM TO: 660-886-2121
OR MAIL TO: RED CROSS PHARMACY
161 SOUTH BENTON
MARSHALL, MO 65340

PLEASE PLACE COPY OF INSURANCE CARD HERE

Missouri Department of Health and Senior Services
TUBERCULOSIS HISTORY

PO Box 570
Jefferson City, Missouri 65102

Patient's Name _____ Age ____ Date of Birth____/____/____ Sex M F

To be completed by the Local Health Department Nurse.

TB History completed by:_____ Date: ____/____/____ County:_____

TB Treatment: ☐ Pulmonary ☐ Extrapulmonary _____ (site)

Bacteriology: Smear_____ Culture _____ NAA_____ **CXR:** ____ Normal ___Abnormal ___ Cavitary ___ Noncavitary ____ Not done

Initial drug regimen started:_____/_____/_____ _ __INH (dosage)_____ ____ Rifampin (dosage)_____

____ PZA (dosage)_____ ____ Ethambutol (dosage)_____ ___ Other_____

Frequency: ____ Daily ____Twice weekly ____ Thrice weekly

Treatment Plan:_____ months. _____ Ethambutol discontinued _____/_____/_____ PZA discontinued _____/_____/_____

_____ INH discontinued _____/_____/_____

Continuation Phase Drug Regimen:

____INH (dosage)_____ ____ Rifampin (dosage)_____ ____Other_____

Frequency: ____ Daily ____Twice weekly ____Thrice weekly

List additional medications patient currently taking taking:_____

Reported Allergies:

Medical risk/social factors: Circle the appropriate answer to all questions

Y/N/U Contact to case _____	Y/N/U Abnormal CXR/old TB	Y/N/U Prior TB- inadequate treatment
Y/N/U PPD Convertor	Y/N/U Foreign born in US < 5 years	Y/N/U Excessive alcohol usage
Y/N/U Injectable drug use (within last year)	Y/N/U Non-injectable drug use (within last year)	Y/N/U Incarceration at time of diag
Y/N/U Homeless (within past year)	Y/N/U High risk employment_____	Y/N/U Resident/long term care
Y/N/U < 10% below ideal body weight	Y/N/U Diabetes	Y/N/U Cancer
Y/N/U HIV/AIDS	Y/N/U Rheumatoid arthritis	Y/N/U Crohn's disease
Y/N/U Was HIV/AIDS testing offered	Y/N/U Dialysis/Renal failure	Y/N/U Gastrectomy/intestinal bypass
Y/N/U Steriod therapy	Y/N/U Silicosis	Y/N/U Unable to read/understand directions
Y/N/U Organ transplant	Y/N/U Mental illness	Y/N/U Other_____

Date of onset of cough: _____/_____/_____ ___ Hemoptysis ____/____/____ Night sweats ____/____/____ ___Fever ____/____/____

____ Weight loss ____/____/____ ___Chest pain ____/____/____ ___Enlarged lymph nodes ____/____/____ ___ Other ____/____/____

Date of diagnosis: _____/_____/_____ Delays in diagnosis:_____

PPD done at diagnosis ____ Yes ____No Results _____ MM Date: _____/_____/_____

Previous PPD: ____ Yes ____No Results _____ MM Date: _____/_____/_____

LTBI Treatment received ____ Yes ____No Date: _____/_____/_____ Medications_____

To be completed by State Date reported to DHSS ____/____/____ By whom: LPHA, Hospital, Physician, other_____

Genotyping Results: Spoligo_____ MIRU_____ RFLP_____

Matches ____No _____ Yes RVCT# _____ RVCT#_____ RVCT#_____

Missed opportunity for preventing TB

____ Preventable: TB Risk factor, no PPD

____ Preventable: LTBI, No treatment (Excluding documented refusal)

____ Preventable: LTBI, incomplete treatment

____ Preventable: Contact to case, not identified prior to diagnosis of TB

____ Preventable: Secondary case to preventable case

____Not Preventable: Appropriate testing &/or treatment prior to diagnosis of TB

____Not Preventable: Foreign born, TB identified on entry into US

____Not Preventable: Recent entry to US, no exam abroad or in US prior to diagnosis of TB

Missed opportunity for preventing TB death

Was TB cause of death: ____ Yes ____No

Was TB a contributing factor to death: ____ Yes ____No

Was TB treatment cause of death: ____ Yes ____No

Was TB treatment a contributing factor: ____ Yes ____No

Missouri Department of Health and Senior Services

Tuberculosis Worksheet For Contacts of Newly Diagnosed Cases of TB

	Date	County
TB Index Case Name:	Address:	Date of Birth

TB Index Case Characteristics

1. At time of diadnosis was index case coughing?	2. Positive on AFB sputum smear?	3. Positive on sputum culture?	4. Is index case clinical?	5. Is index case physician diagnosed?
☐ No ☐ es, How Long?_____	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

Name of Contact Identified	Age	Contact High (H) Medium (M) Low (L)	Mantoux Tubercilin Test						X-Ray		Treatment			Comments
			Previous positiveskin test (Y/N)	Date of previous skin test	Date of initial test	mm	Date of follow-up test	mm	Date	Results Normal(N) Abnormal (A)	Started Treatment (Y/N)	Start Date	Stop Date	
1. Name														
Address														
2. Name														
Address														
3. Name														
Address														
4. Name														
Address														
5. Name														
Address														
6. Name														
Address														
7. Name														
Address														
8. Name														
Address														

For Contacts of Newly Diagnosed Cases of TB (page 2)

Name of Contact Identified	Age	Contact High (H) Medium (M) Low (L)	Mantoux Tubercilin Test						X-Ray		Treatment			Comments
			Previous positiveskin test (Y/N)	Date of previous skin test	Date of initial test	mm	Date of follow-up test	mm	Date	Results: Normal(N) Abnormal (A)	Started Treatment (Y/N)	Start Date	Stop Date	
9. Name														
Address														
10. Name														
Address														
11. Name														
Address														
12. Name														
Address														
13. Name														
Address														
14. Name														
Address														
15. Name														
Address														
16. Name														
Address														
17. Name														
Address														
18. Name														
Address														

SMEARS			CULTURES			X-RAYS			MEDICATION AND DOSAGE							
DATE	RESULT	LAB #	SPEC	RESULT	LAB	DATE	RESULT	WHERE?	DATE	INH	RIF	EMB	PZA	OTHER	COMPLIANCE	MED. EVAL
						Cavitary - 1										
						Noncavitary - 2										

COMPLIANCE CODES ► **1.** TAKING ALL MEDS. **2.** OCCASIONALLY MISSES DOSES **3.** FREQUENTLY MISSES DOSES **4.** TAKES ERRATICALLY **5.** PROBABLY NOT TAKING MEDS. **6.** NOT TAKING MEDICATION **7.** DOT

IDENTIFICATION INFORMATION AND PERSONAL HISTORY

AGE	SEX	RACE	REPORTED BY (NAME OF PHYSICIAN, HOSPITAL, ETC.)	
		☐ 1. WHITE ☐ 2. BLACK ☐ 3. ASIAN OR PACIFIC ISLANDER ☐ 4. AMERICAN INDIAN OR ALASKAN NATIVE ☐ HISPANIC ☐ NON-HISPANIC		
DOB			ADDRESS	PHONE NO.

PATIENT'S ADDRESS

1.	DATE
2.	DATE
3.	DATE
4.	DATE

MANTOUX: ☐ POSITIVE _____ mm ☐ NEGATIVE _____ mm

Date: _____

HIV ☐ POSITIVE ☐ NEGATIVE ☐ NOT DONE

PREVIOUS SKIN TEST

TYPE

DATE

PREVIOUS DISEASE? ☐ YES ☐ NO

WHERE REPORTED? _____

IF YES, INDICATE YEAR OF PREVIOUS DIAGNOSIS ► _____.

IF MORE THAN ONE PREVIOUS EPISODE CHECK HERE ► ☐

HOSPITALIZATION

HOSPITAL AND ADDRESS	ADMISSION	DISCHARGE	HOSPITAL NO.
1.			
2.			
3.			
4.			

NOTES

Provider Decision		
Contact is Lost to Follow-up		
Contact Chose to Stop		
Adverse Effect of Medicine		
Active TB Developed		
Contact Moved (follow-up unknown)		
Death		
Reasons Treatment Not Completed:		
Completed Treatment		
Started Treatment		
Latent TB Infection		
TB Disease		
Evaluated		
Number of Contacts		
	SPUTUM SMEAR +	**SPUTUM SMEAR - CULT. +**

NAME (LAST, FIRST)	CASE NO.	DATE CASE ENTERED	COUNTY

☐ REPORTED AT TIME OF DEATH ☐ PRIMARY ☐ SECONDARY	DATE OF DEATH	**INSTITUTION** ☐ MENTAL ☐ PENAL ☐ NURSING HOME	INSTITUTIONALIZED PRIOR TO DIAGNOSIS ☐ YES ☐ NO
DATE CLOSED	REASON CLOSED	INSTITUTION NAME	INSTITUTION ADDRESS

SITE

☐ PULMONARY ☐ LYMPHATIC ☐ GENITOURINARY ☐ MENINGEAL ☐ OTHER (SPECIFY)

☐ PLEURAL ☐ BONE &/OR JOINT ☐ MILIARY ☐ PERITONEAL _____

SIGNIFICANT SITE(S) OTHER THAN PREDOMINANT SITE ►

DATE OF DRUG RESISTANT CULTURE ►

RESISTANT TO WHAT DRUGS? _____

Risk Factors: _____

Additional Risk Factors: _____

Record positive smears in red or highlight.

LFT Results:

Date: _____

☐ Normal ☐ Elevated

CXR Abnormalities

Foreign Born: ☐ YES ☐ NO

Date entered U.S.: _____

Literature: ☐ YES ☐ NO

SMEARS			CULTURES			X-RAYS			MEDICATION AND DOSAGE							
DATE	RESULT	LAB #	SPEC	RESULT	LAB	DATE	RESULT	WHERE?	DATE	INH	RIF	EMB	PZA	OTHER	COMPLIANCE	MED. EVAL

Missouri Department of Health and Senior Services
Tuberculosis Medication Record

Name	Start Date ____/____/____	Allergies

INH = Isoniazid RIF = Rifampin PZA = Pyrazinamide EMB = Ethambutol B-6 = Pyridoxine

Admin Codes: D = DOT S = Self Administered F = Failed Dose (In Red) H = Held Dose DC = Discontinued SU = Set up X = Special Circumstance

(If given by DOT the health care worker and patient should initial the form each day medication is given/ingested)

Month	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Administration Code																															
Meds/Dose/Frequency																															
INH																															
RIF																															
PZA																															
EMB																															
B6																															
Other																															
Nurse Initials																															
Client Initials																															

Observer Signature	Initials	Patient Signature	Initials

Completed doses taken this month _____ daily _____ 2x/wk _____ 3x/wk

Completed doses taken to date ____ daily _____ 2x/wk _____ 3x/wk

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

TUBERCULIN SKIN TEST RECORD

NAME
DATE OF BIRTH
ADDRESS
CITY, STATE, ZIP CODE
SEE BACK OF CARD FOR SKIN TEST RESULTS

MO 580-0840 (6-02) TBC-18

DATE		TEST TYPE	PROVIDER & AGENCY SIGNATURE	RESULTS
GIVEN MO/DAY/YR	READ MO/DAY/YR			
				mm
				mm
				mm
				mm
				mm
				mm
				mm
COMMENTS				
RETAIN THIS DOCUMENT AS PROOF OF TUBERCULIN SKIN TESTING				

Missouri Deaprtment of Health & Senior Services

Certificate of Completion for TB Treatment

_____

has successfully completed _____ months
of treatment for Tuberculosis/LTBI

For more information, contact:
_____ County Health Department

Telephone: ( ) _____

MO 580-2689 (12-03) TBC-19

Meds:	Dosage	Date Started	Date Completed
INH			
RIF			
PZA			
EMB			
SM			
Last negative culture:			Date:
Last CXR results:			Date:
PPD results:		mm	Date:

MO 580-2689 (12-03) TBC-19

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR COMMUNICABLE DISEASE PREVENTION

DIAGNOSTIC SERVICES ELIGIBILITY/AUTHORIZATION (TB)

PATIENT'S NAME			SEX ☐ MALE ☐ FEMALE
ADDRESS	CITY	COUNTY	ZIP CODE
TELEPHONE ( )	SOCIAL SECURITY NUMBER	BIRTHDATE (MONTH/DAY/YEAR)	
1. IS PATIENT COVERED BY MEDICAID OR MEDICARE? ☐ YES ☐ NO	2. IS PATIENT COVERED BY ANY OTHER HEALTH INSURANCE? ☐ YES ☐ NO	3. IS PATIENT COVERED BY VA BENEFITS? ☐ YES ☐ NO	

I affirm by my signature (mark) that the above statements are true to the best of my knowledge. I understand Diagnostic Services are for evaluation of TB infection/disease (initial office visit, chest x-ray) with subsequent follow-up visits if necessary and approved through the _____ County/City Health Department by the Disease Investigation Unit. **Diagnostic Services will only pay for office visits, chest x-ray and sputum induction (if needed). Any other services obtained are not covered and are the responsibility of client (e.g. CT scans and routine labs).**

I also give my permission to the _____ County/City Health Department to share needed information with the provider to obtain these services and also authorize the care provider to share information with the county/city health department.

SIGNATURE OF CLIENT OR PARENT/GUARDIAN (IF CLIENT IS A MINOR)	DATE

DATE PPD TEST GIVEN	DATE READ	RESULTS	RISK FACTORS

PHYSICIAN PROVIDER			
PHYSICIAN ADDRESS	CITY	COUNTY	TELEPHONE
HEALTH DEPARTMENT EMPLOYEE SIGNATURE/HEALTH DEPARTMENT			DATE

DHSS USE ONLY

PRE-AUTHORIZATION NUMBER	DATE AUTHORIZED	AUTHORIZED BY

TYPE OF SERVICE NEEDED	UNITS AUTHORIZED
☐ FIRST OFFICE VISIT (99205)	
☐ SUBSEQUENT OFFICE VISITS (99215)	
☐ CHEST X-RAY (71020)	
☐ CHEST X-RAY INTERPRETATION (71020A)	
☐ INDUCED SPUTUM COLLECTION (89350)	
☐ OTHER	

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. I have had the recommended course of treatment for **tuberculosis infection** (LTBI).

[ ] I am tuberculin positive. I have had the recommended course of treatment for **tuberculosis disease**.

[ ] I am tuberculin positive. I have had one negative chest x-ray since becoming tuberculin skin test positive.

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

_____ _____
Patient Date

Check list for Active Disease Case

INITIAL WORKUP:

	YES	NO	NA	Notes
CD-1 completed				
Conduct patient interview				
Complete TB History (TBC-10) Form				
CD-1&TB History Form faxed/ mailed to state TB nurse				
Release of information signed				
Contact/source case investigation initiated				
Patient education provided in client's primary language and documented, Isolation procedures as needed				
Admission note completed				
Sputums sent to MRC for culture & sensitivity				
Diagnostic services arranged, if needed				
HIV testing offered				
Baseline LFT and eye exam, if applicable				
Prescriptions obtained and faxed to state contract pharmacy				
DOT initiated				
Contact form mailed to district office (TBC-13)				

DURING TREATMENT:

	MONTH 1	MONTH 2	MONTH 3	MONTH 4	MONTH 5	MONTH 6
Assess & document on TBC-1						
LFT, if indicated						
DOT (# of doses this month)						
Sputums submitted						
TBC-1 sent to state TB nurse						

COMPLETION OF TREATMENT:

	YES	NO	Notes
Completion of therapy documented (including # of doses received)			
Completion letter to client			
State TB Nurse notified			

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

PARTICIPATION AGREEMENT FOR PROFESSIONAL AND SPECIAL SERVICES PROVIDER

AGREEMENT NUMBER	O.A. VENDOR NUMBER

FUNDING SOURCE

FEDERAL AGENCY NAME	FEDERAL AWARD YEAR	STATE %	FEDERAL %
FEDERAL AWARD NUMBER		RESEARCH & DEVELOPMENT YES☐ NO ☐	SUBJECT TO A-133 REQUIREMENTS YES☐ NO ☐
FEDERAL AWARD NAME		CFDA NUMBER	CFDA TITLE

1. By signing below the Provider agrees to provide services or goods as needed to Missouri Department of Health and Senior Services (hereinafter referred to as Department) approved clients.
2. This agreement shall consist of this form, the attached Business Associate Provisions document, and the attached Terms and Conditions document which are incorporated herein by reference.
3. The Provider shall comply with the policies and procedures required by the Department in the delivery of services, supplies, appliances or pharmaceuticals and in submitting claims for payment, as described in the Program Billing Guidelines which are incorporated herein as if fully set out. The Department shall provide guidelines to the Provider.
4. Services authorized and resulting charges are subject to review and approval by the Department. Payments for service shall be in accordance with Program Billing guidelines in effect at the time services are provided.
5. The Provider shall make all reasonable efforts to pursue third-party payments for services subject to this agreement, unless otherwise indicated in Program Billing Guidelines. The Department must be notified within sixty (60) days of the Provider's receipt of third-party payment.
6. The Provider shall not require or request payment for authorized services from clients covered by this Agreement. The Provider shall have the express right to bill clients covered under this Agreement for services that are not authorized. Unauthorized services are those for which the Department has not given specific prior authorization. All billings for services provided to approved clients must be submitted to the Department no later than sixty (60) days following the date of services provided except that all bills must be submitted no later than thirty (30) days after the close of the state fiscal year on June 30, of each year.
7. Obligations under this agreement shall be suspended at such time as funds are not available to cover payment for services provided to qualified clients. However, suspension shall not eliminate coverage under this agreement for services which had been approved by the Department and which had already been furnished prior to the date of suspension.
8. This agreement shall be effective on the date of approval by the Department and shall continue in effect until such time as either party invokes termination as set forth in the attached Terms and Conditions document. Following any three- year period during which no services have been provided by the Provider in regard to this agreement, this agreement shall cease.
9. The Provider acknowledges that pursuant to the Federal Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164), it is a business associate of the Department and it shall comply with the additional Business Associate Provisions document attached hereto and incorporated herein by reference.
10. If the Provider has not already submitted a properly completed State Vendor ACH/EFT Application for deposit into a bank account of the Provider, such Application shall accompany the partially-executed Agreement at the time the Provider returns the Agreement to the Department, as the Department will make payments to the Provider through Electronic Funds Transfer. Payment may be delayed until the ACH/EFT application is completed and approved.

PROVIDER NAME (PLEASE TYPE)	PAYMENT MAILING ADDRESS (STREET, CITY, STATE, ZIP)
NAME OF AUTHORIZED REPRESENTATIVE	
SIGNATURE OF PROVIDER OR REPRESENTATIVE DATE ▶	E-MAIL ADDRESS

FEDERAL TAX I.D. OR SOCIAL SECURITY NO.	STATE LICENSE NO. (IF APPLICABLE)	TELEPHONE NUMBER

TYPE OF PROVIDER

☐ HOSPITAL ☐ PHARMACY ☐ DENTIST ☐ THERAPIST

☐ PHYSICIAN (M.D./D.O.) ☐ OTHER

CERTIFIED MINORITY OR WOMEN BUSINESS ENTERPRISE (MBE / WBE)

☐ YES ☐ NO

PROVIDER ENROLLMENT APPROVED

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES, DIVISION OF ADMINISTRATION DIRECTOR OR DESIGNEE ▶	TITLE **Director or Designee, Division of Administration**	DATE

Missouri Department of Health and Senior Services
Progress Notes

Client Name (Last, First, Middle)	Agency	DCN/SSN/DOB

Date/Type of Contact	NOTES

Date/Type of Contact	NOTES

Tuberculosis Signs & Symptoms Checklist

Client Name:_____ Date:_____

1. Have you ever had a positive TB skin test?	Yes	No
If yes, have you received treatment?	Yes	No
When_____		
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. Have you recently been treated for cancer?	Yes	No
15. Have you ever been diagnosed with hepatitis or liver disease?	Yes	No
16. Do you drink alcohol?	Yes	No

17. What is your current method of birth control?_____

18. Are you pregnant?_____ Date of LMP:_____

19. How long have you lived in the United States?_____

Comments:_____

_____

_____

HOJA DE ENTREVISTA DE TUBERCULOSIS

Nombre:_____ Fecha:_____

1. Usted ha tenido siempre una prueba positiva de la tuberculosis?	SI	NO
Si si, usted ha recibido el tratamiento?	SI	NO
Cuando? _____		
2. Usted fuma?	SI	NO
3. Tiene usted tos?	SI	NO
4. Usted tose cualquier cosa?	SI	NO
5. Usted tose sangre?	SI	NO
6. Ha perdido peso?	SI	NO
7. El appetite ha disminuido?	SI	NO
8. Tiene fibre o escalofrios?	SI	NO
9. Usted suda en la noche?	SI	NO
10. Tiene dolor en el pecho?	SI	NO
11. Usted se siente inusualmente cansado o debil?	SI	NO
12. Usted ha estado en contacto cercano con alguien que tien tuberculosis?	SI	NO
13. Usted ha tomado el prednisone o los esteroides recientemente?	SI	NO
14. Ha tenido algun tratmiento para el cancer recientemente?	SI	NO
15. Le siempre han diagnosticado con hepatitis o enfennedad del higado?	SI	NO
16. Usted bebe el alcohol?	SI	NO

17. Se usa anticonseptivos?
Cual tipo? Patillas _____ Inyeccion _____ Condoms _____

18. Esta embarazada? SI NO La fechna de la utima regla:_____

19. Cuanto tiempo lleva en los Estados Unidos?_____

COMENTARIOS:_____

_____