sonoma county
DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH DIVISION

Tina Rivera – Director
Sundari R. Mase, MD, MPH – Health Officer

Date: ________________________

Patient Name: ____ DOB: ________________________

Mailing address: ____

Telephone: (Home) (_____)________________ (Work) (_____)______________(Cell/Msg) (_____)____________________

Language(s) **(mark all that apply)**: ENGLISH ❒ No ❒ Yes SPANISH ❒ No ❒ Yes OTHER ❒ ___________________

Regular health provider: ____

HISTORY

1. Previous diagnosis of TB or LTBI: ❒ None ❒ TB Disease ❒ LTBI	**IF YES, WHEN/ WHERE?**
2. History of prior TB/LTBI treatment: ❒ None ❒ TB Disease ❒ LTBI	**IF YES, WHEN/ WHERE? WHAT DRUGS?**
3. Previous TST (PPD) **Result—Mark one of the following boxes:** ❒ No prior TST (PPD) ❒ Prior documented TST ______ mm. (induration) Date Placed: ________ Date Read: ________Where: ___________________ ❒ Prior undocumented TST (per pt report) ❒ Pos. ❒ Neg Date_________ Where:_____________________________________ ❒ Unknown	

TB TEST RESULTS

4. Current Tuberculin Skin Test (TST/PPD) **Result—**Please indicate mm **size** of induration
Size recorded in mm: __________________ mm. (induration)Date Placed: __________________ location: LFA RFA ______
Date Read: ___________________________ Provider: ____

5. IGRA (TB blood test) **Result—Attach lab report.**
Date: _______________________________________ Result: ❒Negative ❒Positive ❒Indeterminate
❒ Quantiferon-TB Gold In-Tube ________________________________IU/ml ❒ T-Spot.TB _____spot count #

6. Chest X-Ray—Attach current/prior reports if possible.
❒ Chest x-ray NOT ordered.
❒ Chest x-ray ordered. Date: _________________ Facility Name: __________________________ Result: _______________
❒ X-ray result pending.
❒ X-ray report attached.

DOES PATIENT HAVE SYMPTOMS OF TB?

7. Symptoms				**8. Risk Factors**			
Cough	❒ No	❒ Yes	Onset Date ______________	Contact to TB Case	❒ No	❒ Yes	❒ Unk
Fatigue	❒ No	❒ Yes	Onset Date ______________	Diabetic	❒ No	❒ Yes	❒ Unk
Fever	❒ No	❒ Yes	Onset Date ______________	Foreign Born	❒ No	❒ Yes	❒ Unk
Anorexia	❒ No	❒ Yes	Onset Date ______________	Recent Travel	❒ No	❒ Yes	❒ Unk
Night Sweats	❒ No	❒ Yes	Onset Date ______________	HIV+	❒ No	❒ Yes	❒ Unk
Hemoptysis	❒ No	❒ Yes	Onset Date ______________	Homeless	❒ No	❒ Yes	❒ Unk
Weight Loss	❒ No	❒ Yes	Onset Date ______________	IVDU	❒ No	❒ Yes	❒ Unk
				Recent Incarceration	❒ No	❒ Yes	❒ Unk

Form completed by: ____ Date: __________________

Notes: