GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
TUBERCULOSIS CASE REPORT

Name:	**SSN#**	**Date of Report:**
Address:	**Telephone #**	**Date of Birth:**

Marital Status:	**Sex:**	**Race:**	**Country of Origin if not U.S.**
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	☐ Female ☐ Male	☐ Black ☐ American Indian or Alaskan Native ☐ White ☐ Asian or Pacific Islander **Ethnic Origin:** ☐ Hispanic ☐ Not Hispanic ☐ Define _____	_____ **Date arrive in U.S.** _____

Occupation	**Place of Employment**	**Address**

Classification	**Diagnosis**	**Bacteriology**
☐ Tuberculosis current disease ☐ Tuberculosis No current disease ☐ Tuberculosis suspect ☐ Tuberculosis infection No disease Signs and Symptoms: _____ _____	☐ Pulmonary ☐ Non-Pulmonary ☐ Miliary ☐ Meningitis ☐ Bones and Joints ☐ Pleural ☐ Lymphatic ☐ Peritoneal ☐ Genito-Urinary ☐ Other (specify) ☐ Reported at time of death Immunocompromised ☐ Neg ☐ Pos	POS. NEG. Pending Not Done Smear ☐ ☐ ☐ ☐ Culture ☐ ☐ ☐ ☐ **Type of Specimen** ☐ Sputum ☐ Fluid ☐ Tissue ☐ Other (specify) _____ _____ (date(s) of collection) _____ Laboratory Performed

Chest X-Ray	**Tuberculin Skin Test**	**Chemotherapy Dosage**
☐ Not done ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non-cavitary ☐ Stable ☐ Worsening ☐ Improving _____ Date of X-Ray Comments:	☐ Not done ☐ Mantoux ☐ Tine ☐ Other (specify) _____ ☐ Significant Size (mm) _____ ☐ Not significant _____ Date Read	☐ Isoniazid ☐ Rifampin ☐ Ethambutol ☐ Pyrazinamide ☐ Streptomycin ☐ Other (specify) _____ _____ Date started

Patient to be followed by: _____ (Name) (Address) (Phone)	Previous Diagnosis: ☐ Yes ☐ No Date: _____

Comments: ☐ Send Additional Report Forms	Hospitalization Chart No. Admission Date: _____ Discharge Date: _____

Reported by	Signature	Office or Hospital Address

Source #	Ward	Census Tract	Date Received	Case #	Verified

Please fax TB Case Report to (202) 724-2363 Attn: Registry