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

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DOH
DEPARTMENT OF HEALTH
Promote. Prevent. Protect.

Name: **SSN#** **Date of Report:**

Address: **Telephone #** **Date of Birth:**

Marital Status:
Single
Married
Divorced
Separated
Widowed

Sex:
Female
Male

Race:
Black
White
American Indian or Alaskan Native
Asian or Pacific Islander

Ethnic Origin:
Hispanic Not Hispanic Define _____

Country of Origin if not U.S.
_____

Date arrive in U.S.
_____

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

Classification
Tuberculosis current disease
Tuberculosis No current disease
Tuberculosis suspect
Tuberculosis infection No disease

Signs and Symptoms:
_____
_____

Diagnosis
Pulmonary
Non-Pulmonary
Miliary
Meningitis
Bones and Joints
Pleural
Lymphatic
Peritoneal
Genito-Urinary
Other (specify)
Reported at time of death

Immunocompromised
Neg Pos

Bacteriology

	POS.	NEG.	Pending	Not Done
Smear				
Culture				

Type of Specimen
Sputum Fluid
Tissue Other (specify) _____

_____
(date(s) of collection)

_____
Laboratory Performed

Chest X-Ray
Not done
Normal
Abnormal
Cavitary
Non-cavitary
Stable
Worsening
Improving

_____
Date of X-Ray
Comments:

Tuberculin Skin Test
Not done
Mantoux
Tine
Other (specify) _____
Significant Size (mm) _____
Not significant

_____
Date Read

Chemotherapy Dosage
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