Tuberculosis Infection and Disease Report Form

Johnson County Department of Health and Environment
Tuberculosis Control Program
6000 Lamar Ave, Suite 140, Mission, KS 66202
Phone: 913-826-1224 **Fax: 913-826-1300**

Patient's Name:_____ **Date of Birth**: ____ /____ /_____
Last First Middle Month Day Year

Address: _____

Home Phone: _____ **Cell Phone**: _____ **Work Phone**:_____

Place of Employment: _____ **Job Title**: _____

Race: White Black/African American
American Indian/Alaskan Native Asian
Native Hawaiian/Pacific Islander Not Specified

Place of Birth: USA
Other: (specify) _____
Arrived In The US: _____ /_____ /_____

Ethnicity:
Hispanic/Latino Not Hispanic/Latino Unknown

Gender:
Male Female

Reason For Test: Symptomatic Employment School Refugee Group Home Detention/Correctional Facility
(circle all that apply)
Evaluation for TNF-α antagonist Contact to Active TB

Other (Please specify): _____

IF CLIENT HAS HISTORY OF BCG VACCINATION OR IS FOREIGN BORN – IGRA TESTING IS RECOMMENDED

Current TST Placed: ____ /____ / _____ TST Read: ____ / ____ / _____ Induration: _____mm
Previous TST Placed: ____ / ____ / _____ TST Read: ____ / ____ / _____ Induration: _____mm

5 mm or more	10 mm or more	15 mm or more
__HIV Infection __Close Contact To An Active TB Case __Organ Transplant __Fibrotic Changes On CXR Consistent With Old TB __Other Immunosuppressed Clients	__Recent Arrivals From High Prevalence Countries __Injection Drug User __Residents & Employees of High-risk Congregate Setting __Mycobacteriology Laboratory Personnel __Persons With Clinical Conditions That Make Them High-risk * __Children <4 Yrs of Age, or Children & Adolescents Exposed to Adults in High-risk Categories	__No Known Risk Factors

IGRA - TB Blood Test Date: ____ / ____ / _____ Positive Negative ***Attach Lab Results***
(T-Spot/Quantiferon Gold)

Symptoms: Cough (> 3 weeks) Unexplained Fever Night Sweats Hemoptysis Weight Loss
Fatigue Chest Pain Lymphadenopathy Shortness of Breath NONE

Chest X-Ray: ____ /____ / _____ **Results**: Normal Abnormal Pending ***Attach Radiologic Interpretation***

Form Completed By: _____ **Date:** ____ / ____ /_____
(*Please Print*)

Healthcare Facility: _____ **Phone**: _____

Active** Disease Tuberculosis: A Telephone Report Is Required By Law Within **Four** Hours of Suspected or Confirmed Cases

Revised 9/2010, 4/2012, 6/2015,11/2017