

**Texas Department of State Health Services - TB Program
Report of Serious Adverse Drug Reaction Resulting in Hospitalization or Death**

Patient Name _____ SSN _____ Date of Birth _____

This patient is under treatment for (please circle) Latent TB Infection Active TB Disease

Treatment regimen when symptoms of adverse drug reaction were first reported

Name of Drug	Dose	Frequency	Name of Drug	Dose	Frequency
isoniazid			kanamycin		
rifampin			streptomycin		
pyrazinamide			ciprofloxacin		
ethambutol			gatifloxacin		
rifamate			levofloxacin		
rifater			moxifloxacin		
rifabutin			ofloxacin		
rifapentine			cycloserine		
ethionamide			clofazimine		
amikacin			para-aminosalicylic acid		
capreomycin			other (please specify)		

_____ Date symptoms were first reported
Symptoms of adverse drug reaction – please describe

_____ Date of last dose taken

Date Specimen Collected	Laboratory Tests Ordered	Results

_____ Name of hospital _____ City _____ Date of hospital admission _____

_____ Name of physician _____ Phone number _____

_____ Name of health department contact person _____ County _____ Phone number _____

Please describe current status of patient and follow-up plan

_____ Date of hospital release _____ Date of death _____

Please fax this report with a copy of any related TB-400A and TB-400B forms to the Tuberculosis Services Branch - TB at 512-533-3167 within two working days after a serious adverse drug reaction event resulting in hospitalization or death.

