TEXAS Health and Human Services

Texas Department of State Health Services

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Commissioner

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Tuberculosis Branch
Cohort Review Presentation Form

Quarter: □ Q1 □ Q2 □ Q3 □ Q4	Cohort Year:	Presentation Date:
Primary Case Manager:	Contact Investigator:	Treating Physician:

Section 1: Patient Information

RVCT #:	Date of Birth:
Patient Name:	Gender: □ Male □ Female
Date Case was Counted:	Country of Birth:

Medical Risks (check all that apply):

- □ Diabetes Mellitus
- □ Alcohol Abuse (within past year)
- □ Tobacco Use
- □ Silicosis
- □ Corticosteroids or Other Immunosuppressive Therapy
- □ Gastrectomy or Jejunoileal Bypass
- □ Age < 5 Years
- □ Recent Exposure to TB (contact to TB case)
- □ Contact to MDR-TB
- □ Weight at Least 10% Less Than Ideal Body Weight
- □ Chronic Malabsorption Syndromes
- □ Leukemia
- □ Lymphoma
- □ Cancer of Head
- □ Cancer of Neck
- □ Drug Abuse within Past Year
- □ TB Test Conversion in Last 2 Years
- □ Fibrotic Lesions (on chest X-ray) Consistent with Old, Healed TB
- □ Chronic Renal Failure
- □ Organ Transplant
- □ Other: _____

Code 900: □ Not Offered □ Refused
Collection Date: _____ Results: □ Positive □ Negative □ Pending
CD4 Count, if positive:

Section 2: Diagnostic Information

Disease Site:	Initial Chest X-ray Date: _____ □ Normal □ Abnormal □ Abnormal/Cavitary □ Not Done
Collection Date of Initial Positive AFB Smear:	Collection Date of Initial Positive MTB Culture:

Resistance: □ Yes □ No If Yes, Resistant to:

Section 3: Treatment Completion Information

Treatment Start Date:	Treatment Completion Date:
Collection Date of First Consistently Negative AFB Smear:	Collection Date of First Consistently Negative MTB Culture:

If Treatment Not Completed, check all that apply:

- □ Still on Therapy (Planned Completion Date: _____)
- □ Treatment Interruption (□ Adverse Reaction □ Patient Non-adherence □ Provider Decision)
- □ MDR
- □ Lost
- □ Reported at Death
- □ Inter-jurisdictional Transfer (To: _____ Date: _____)
- □ Other:
- □ Refused (Reason:_____)
- □ Died (Date: _____)
- □ Moved out of Country(To: _____)

If Not on DOT Explain:
Number of Recommended Doses: Number of Doses Taken:

Section 4: Contact Investigation Results	
Genotyped: □ Yes □ No If Yes, GENType:	
Number of Contacts Identified:	Number of Contacts Evaluated:
Number of Documented Prior Positives:	
Number of Contacts Infected without TB Disease:	
Number of Contacts Identified as AFB Smear Positive:	
Number of Contacts Identified with TB Disease:	
Number of Contacts Eligible for Treatment of TB Infection (TBI):	
Number of Contacts that Started Treatment for TBI: Recent Documented Conversions: _____ Children ≤ 5 Years:_____ Known HIV+ Status: _____	
Number of Contacts Currently on Treatment for TBI:	
Number of Contacts that Completed Treatment for TBI: Recent Documented Conversions: _____ Children ≤ 5 Years:_____ Known HIV+ Status: _____	
Number of Contacts that Did Not Complete Treatment for TBI Due To: _____Still on Treatment _____Adverse Reactions _____Died _____Moved _____Refused _____Lost _____Provider Decision (Unable to Monitor Patient Care) _____Other:	
Percentage of Contacts Infected: (Formula: Number of Contacts Infected – Prior Positives / Number Evaluated – Prior Positives x 100%)	