TUBERCULOSIS CASE MONTHLY REPORT

Submit 1st day of every month- *new information from last report only*

Department of Public Health & Human Services
TB Program
Cogswell Building, Room C-216
1400 Broadway, Helena, MT 59620
Phone: 406-444-0275; Fax: 406-444-0272

Today's Date: ____________________

Submitted By: ____________________

Agency: ____________________

Phone: ____________________

This Report is being submitted for: Month __________ Year __________

Patient Name: ____________________
City: ____________________ County: ____________________

Diagnostic Update: (Sputum Smear Conversion: Collect until 3 consecutive negative results; Sputum Culture Conversion: Collect until 2 consecutive negative results)

Test	Date Collected	Result	Test	Date Collected	Result
AFB Smear			M.tuberculosis Culture		
AFB Smear			M.tuberculosis Culture		
AFB Smear			M.tuberculosis Culture		
AFB Smear			M.tuberculosis Culture		
AFB Smear			M.tuberculosis Culture		

X-Ray: Date: __________ Result: __________
HIV: Date: __________ Result: __________
Other Tests: __________ Date: __________ Result: __________
Most Recent Medical Exam: Date: __________ Result: __________

Symptoms: ( ) Cough ( ) Productive cough ( ) Fever ( ) Night Sweats
( ) Chest Pain ( ) Weight Loss ( ) Other, specify: __________

Hospitalization: Date: __________ Admitting Diagnosis: __________

Medication - Treatment and Adherence:
DOT Plan (describe) __________
Self-Administration: __________
Breaks in Therapy: (give specific dates, doses, reason) __________

List medication side effects: __________

Medication	Dose	Date Started	Projected Length of Therapy	Date Treatment Completed	Date Meds Dc'd and reason e.g. side effects, resistance, moved
Isoniazid -INH					
Rifampin - RIF					
Pyrazinamide - PZA					
Ethambutol - EMB					
Other:					

Therapy Completed & Case Closed: ____________________ (This will be the final report.)

MT DPHHS 4/2007