

Washington State TB ECHO Patient Intake Sheet



DOH 343-135 April 2016

Please describe your primary clinical question(s) regarding the case:

Section 1. Case Information and Patient Demographics

TB ECHO #:		Report Date:	Initial Report Date:	Facility Name:	Managing Provider:
Sex at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Age:	Weight: BMI:	Race: <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native		
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino	Immigration Status when arrived in U.S.:	Country of Birth:	Year Immigrated to U.S.:	History of BCG <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Section 2. Tuberculosis Risk Factors, Symptoms, and Other Conditions

TB Signs & Symptoms (check all that apply):

<input type="checkbox"/> Asymptomatic	<input type="checkbox"/> Night Sweats Duration: _____	<input type="checkbox"/> Unexplained Weight Loss Duration: _____
<input type="checkbox"/> FEVER ($\geq 100^{\circ}\text{F}$ or $\geq 38^{\circ}\text{C}$) or Chills Duration: _____ Recent Temperature: _____ ^o F/C	<input type="checkbox"/> Weakness or Fatigue Duration: _____	<input type="checkbox"/> Chest Pain: _____ Duration: _____
<input type="checkbox"/> Cough > 3 Weeks in duration	<input type="checkbox"/> No Appetite Duration: _____	<input type="checkbox"/> Other Symptom(s): _____ Duration: _____
<input type="checkbox"/> With Blood <input type="checkbox"/> With Sputum Duration: _____		

Section 3. TB Testing

Section 4. Radiology and Treatment

Section 5. Notes