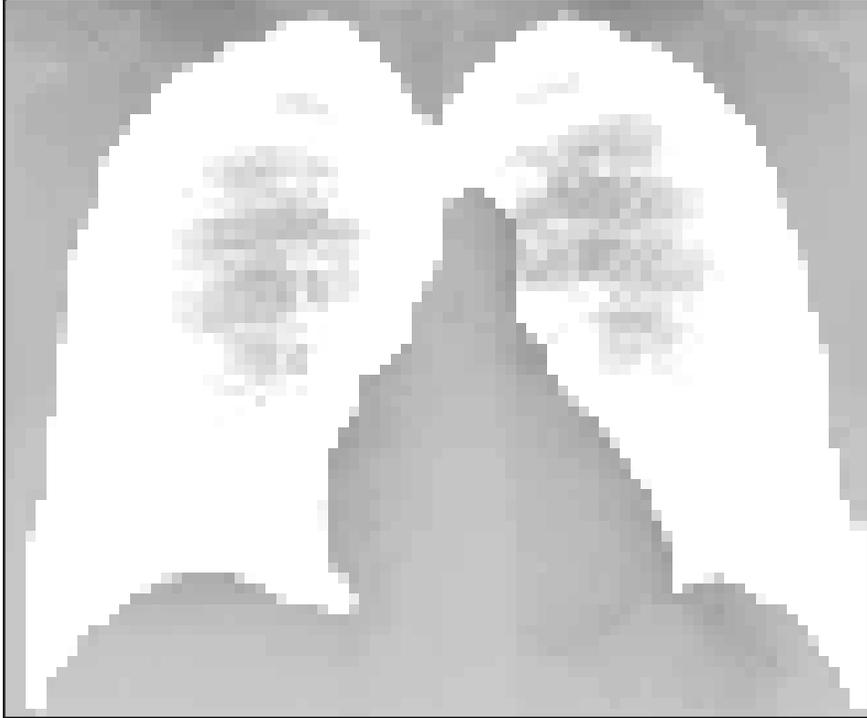


Client Name _____ Birth Date _____

MD SECTION

X-RAY

View			Date Taken	Where Taken	Results				If Abnormal	Status					
P/A	Lat	Other			NI	Abn	Not Done	Unknown	Cavitary	Non-Cavitary	Consistent w/TB?	Stable	Worsening	Improving	Unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> consistent <input type="checkbox"/> not consist.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> consistent <input type="checkbox"/> not consist.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



WORKING DIAGNOSIS / CLASSIFICATION	
<input type="checkbox"/>	0: Not Exposed, Not Infected
<input type="checkbox"/>	1: Exposed, Not Infected
<input type="checkbox"/>	2: Infected, No Active Disease
<input type="checkbox"/>	3: Tuberculosis – Active Disease
<input type="checkbox"/>	4: Tuberculosis – No Active Disease
<input type="checkbox"/>	5: Suspect
<input type="checkbox"/>	Other: _____

Y	N	ADDITIONAL ORDERS
<input type="checkbox"/>	<input type="checkbox"/>	r Sputum x 3 for AFB
<input type="checkbox"/>	<input type="checkbox"/>	r F/U CXR: ___ Cultures Final ___ End Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	r Isolate
<input type="checkbox"/>	<input type="checkbox"/>	r X-ray, Lordotic View
<input type="checkbox"/>	<input type="checkbox"/>	r Routine Medication Education
<input type="checkbox"/>	<input type="checkbox"/>	r Monthly Clinical Evaluation
<input type="checkbox"/>	<input type="checkbox"/>	r Hepatic Profile Baseline & Monthly
<input type="checkbox"/>	<input type="checkbox"/>	r CMP/CBC baseline & monthly
<input type="checkbox"/>	<input type="checkbox"/>	r F/U PPD 12 weeks after last exposure
<input type="checkbox"/>	<input type="checkbox"/>	r MD Office Visit
<input type="checkbox"/>	<input type="checkbox"/>	r MD or Nurse Exam at Rx start
<input type="checkbox"/>	<input type="checkbox"/>	r Refer to primary care for _____
<input type="checkbox"/>	<input type="checkbox"/>	r Other _____

INITIAL TREATMENT ORDERS	
<input type="checkbox"/>	None
<input type="checkbox"/>	INH per protocol X 9 months
<input type="checkbox"/>	B6 per protocol X 9 months
<input type="checkbox"/>	IRZE
<input type="checkbox"/>	Supervision: ___DOT ___Nurse Discretion
<input type="checkbox"/>	Other _____

SITES INVOLVED

<input type="checkbox"/>	Not Applicable
<input type="checkbox"/>	Pulmonary only
<input type="checkbox"/>	Extra pulmonary only (site: _____)
<input type="checkbox"/>	Pulmonary & Extra pulm. (site: _____)

SHD MD COMMENTS

SHD MD SIGNATURE	DATE
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