Washington Department of Health
TB Program
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Washington State Department of Health

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TB ECHO Facsimile Transmission

To:	Lana Tyer	**From:**	
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Phone:	(253) 395-6711	**Pages:**	(+ cover)
Re:	TB ECHO Case Intake	**Date:**	

☐ **Urgent** ☐ **For Review** ☐ **Please Comment**

Case is: ☐ **Symptomatic** ☐ **Asymptomatic**

TB ECHO Case Intake Checklist

- ☐ TB ECHO Intake Sheet
- ☐ TB ECHO Treatment Intake Sheet
- ☐ Documentation of Previous Testing and/or Treatment
- ☐ Lab & Imaging Results
- ☐ Other Documents: _____

Note:

_____

_____

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PUBLIC HEALTH
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Washington State TB ECHO Patient Intake Sheet

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:	Age:	Race:	Ethnicity:
□ Female □ Male		□ White □ Native Hawaiian or other Pacific Islander □ Asian □ Black or African American □ American Indian or Alaskan Native	□ Hispanic or Latino □ Non-Hispanic or Latino

Immigration Status when arrived in U.S.: Immigration Classification:	Country of Birth:	Year Immigrated to U.S.:	History of BCG □ Yes □ No □ Unknown

Section 2. Tuberculosis Risk

Date Patient Presented to Health Care System: _____/_____/_____	Primary Occupation:	Primary Reason for Evaluating TB Status: □ TB Symptoms □ Employment/Administrative Testing □ Abnormal Chest Radiograph (consistent with TB) □ Incidental Lab Result	□ Contact Investigation □ Targeted Testing □ Healthcare Worker □ Immigration Medical Exam □ Unknown

Known Allergies:

Current Non-TB Medication List:

BMI & Weight:

Date Calculated/Measured
_____/_____/_____

Insurance Coverage:
□ Employer □ Individual
□ Medicare □ Medicaid
□ VA/Military
□ Uninsured

Social & Congregate History
□ Alcohol Use — Drinks/Week: _____
□ Drug Use
□ Intravenous Drug Use
□ History of homelessness — Duration: _____
□ History of incarceration — Duration: _____
Notes:

Barriers to Adherence:
Language Barrier?
□ Yes □ No
Cultural Barriers or Barriers related to personal belief / stigma?
□ Yes □ No
Behavioral Health Concerns?
□ Yes □ No

Notes/Clarification:

TB Infection History
□ History of TB Infection

Year of Diagnosis: _____

State or Country:
_____

□ Previous TST or IGRA
Date Collected or Read:
____/_____/_____

_____mm of induration
□ Positive
□ Negative

TB Infection Treatment provided in the past?
□ Yes*
□ No
□ Unknown

Treatment Completed?
□ Yes*
□ No

TB Disease History
□ History of TB Disease

Year of Diagnosis: _____

State or Country:
_____

□ Previous TST or IGRA
Date Collected or Read:
____/_____/_____

_____mm of induration
□ Positive
□ Negative

Previous Contact Investigation?
□ Yes
□ No
□ Unknown

TB Disease Treatment provided in the past?
□ Yes*
□ No
□ Unknown

Travel History:

Village/City/State	Province/Country	Arrival Date	Duration of Stay	Exposure to ill persons? (Specify illness.)
				□ No □Yes, _____

*If the patient is currently/previously on treatment for TB Disease/Infection attach documentation of labs/treatment & see "Treatment Intake Sheet".
For any questions please contact Washington DOH TB Program at (360) 236-3443; Fax (360) 236-3405; tbservices@doh.wa.gov

TB Signs & Symptoms (check all that apply):

□ **Asymptomatic**
□ FEVER (≥100°F or ≥38°C) or Chills
Duration: _____
Recent Temperature: _____ ^{0} F/C
□ Cough > 3 Weeks in duration
□ With Blood □ With Sputum Duration: _____
□ Night Sweats
Duration: _____
□ Weakness or Fatigue
Duration: _____
□ No Appetite
Duration: _____
□ Unexplained Weight Loss
Duration: _____
□ Chest Pain: _____
Duration: _____
□ Other Symptom(s): _____
Duration: _____

Conditions & Additional Risk Factors (check all that apply):

□ **No Conditions or Additional Risk Factors**
□ AIDS/HIV Infection
□ Abnormal Chest X-ray
□ Granuloma
□ Fibronodular disease
□ Carcinoma of head and neck
□ Chronic Renal Failure requiring hemodialysis
□ Cigarette Smoker
□ Contact of MDR patient (2 years or less)
□ Contact of Infectious TB Patient (2 years or less)
□ Diabetes Mellitus (All Types)
□ Hepatitis C
□ Chronic Liver Condition (Other than Hepatitis)
□ Pregnant
□ Recent TB Infection (TST conversion ≤ 2 years ago)
□ Transplantation (requiring immuno-suppressant therapy)
□ Silicosis
□ Treatment with glucocorticoids
□ Tumor Necrosis Factor (TNF)-alpha inhibitors (Infliximab/Etanercept)
□ Underweight (< 90 percent ideal body weight or body mass index [BMI] ≤ 20)
□ Young age when infected (0-4 years)

Section 3. Diagnostics and Evaluation

Tuberculin Skin Test*
□ Yes □ No
Date Placed: ____/____/_____
Date Read: ____/____/_____
Results
□ Positive
□ Negative
□ Indeterminate

See TB History for documentation of previous TST _____mm of induration

IGRA*
Date Collected: ____/____/_____
□ T-Spot □ QFT
Results- 1
□ Positive □ Negative □ Indeterminate

Date Collected: ____/____/_____
□ T-Spot □ QFT
Results- 2
□ Positive □ Negative □ Indeterminate

See TB History for documentation of previous IGRA

Other Testing*
□ HIV — Result: □ Positive □ Negative
Date: ____/____/____

□ Hepatitis C — □ Positive □ Negative
Date: ____/____/____

□ Fasting Blood Glucose — □ Positive □ Negative
Date: ____/____/____

□ Hemoglobin A1C — □ Positive □ Negative
Date: ____/____/____

Sputum Smear*
Dates Collected ___/____/____ ; ___/____/____
Results

1st □ Positive □ Negative □ Unknown
2nd □ Positive □ Negative □ Unknown
3rd □ Positive □ Negative □ Unknown

Nucleic Acid Amplification Test*
Specimen Type
□ Sputum □ Other
Date Collected ___/____/____
Result
□ Positive □ Negative □ Indeterminate
□ Unknown

Sputum Culture*
Date Collected:___/____/___
Results
□ Positive □ Negative □ Unknown

Sputum Culture Conversion Documented?
□ Yes □ No □ Unknown

Culture of Tissue and Other Bodily Fluids *
Date Collected ___/____/____
Site: _____
Smear: □ Positive □ Negative □ Unknown
NAAT: □ Positive □ Negative □ Unknown □ Indeterminate
Culture: □ Positive □ Negative □ Unknown Date Reported: ___/____/____

Imaging

Initial Chest Radiograph (CXR)* Date:___/____/____
Results
□ Normal
□ Evidence of TB
□ Other: _____
Evidence of Cavity
□ Yes □ No □ Unknown
Evidence of Miliary TB
□ Yes □ No □ Unknown

Initial CT Scan or Other Chest Imaging* Date : ____/____/_____
Results
□ Normal
□ Evidence of TB
□ Other: _____
Evidence of Cavity
□ Yes □ No □ Unknown
Evidence of Miliary TB
□ Yes □ No □ Unknown

Section 4. Treatment

Is the patient currently on treatment for TB Disease or TB Infection?
TB Infection Treatment □ Yes* □ No
TB Disease Treatment □ Yes* □ No

Section 5. Notes

*If the patient is currently/previously on treatment for TB Disease/Infection attach documentation of labs/treatment & see "Treatment Intake Sheet".
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