STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

Retention and Disposal of Tuberculosis Records

- In general, chest x-ray clinic reports, diagnostic chest clinic reports, tuberculosis correspondence, other tuberculosis reports, and negative routine x-ray records (TB-9 forms – even on deceased persons) should be retained for **5 years.** This is assuming that information has been recorded on patient's chart and register cards.
- Negative skin test records likewise should be retained for 5 years.
- Any mobile x-ray unit cards still on file can be destroyed.
- 14 x 17 x-rays of active or inactive **cases** of tuberculosis – retain **first** film **and** films for the last **5 years.**
- 14 x 17 x-rays on **suspects** for tuberculosis – retain **first** film **and** films for last **5 years.**
- Retain negative **routine** chest x-rays for **5 years.**
- Retain x-rays on **deceased** persons until **2 years after death.**

February 13, 2007

Signed _____
Dominic Gaziano, M.D., Director
Tuberculosis Control Program

Bureau for Public Health
Division of Surveillance and Disease Control
Tuberculosis Control Program
Room 125, 350 Capitol Street
Charleston, West Virginia 25301-3715
(304) 558-3669 or 1-800-330-8126

WEST VIRGINIA TUBERCULOSIS CONTROL PROGRAM

INITIAL CLINICAL EVALUATION FORM

Date of Visit: _____/_____/_____

☐ TB Clinic_____

☐ Private Provider:_____

Address:_____

Phone: (____)_____

I. NAME (L,F):_____

DOB:____/____/_____Where?_____

Address:_____

How long?_____ Phone:_____

II. HX: PPD:_____ Contact____ Converter____ Smokes:____/ppd. Alcohol_____Other_____

Present illness begin:_____

III. FINDINGS: Present **Weight:**_____, Usual Wt.:_____ **Cough**_____ **Lungs:** Clear_____ Rales _____ Wheezing _____

IV. CXR: Date:____/___/_____Heart & lungs wnl:____. No contraindications for work:____.

No evidence of active pulmonary infection:____. No change in CXR since:____/___/_____.

Calcific deposits:____. **Cavity:**_____. Infiltrates:____. Mass/Opacity_____.

Stable____ Improving_____ Worsening_____ Unknown_____ Findings_____

V. BACTERIOLOGY: ☐ No bacteriology pending.

Source:_____ Date Collected____/___/_____

Smear: ☐ Neg. ☐ Pos. ☐ Pending ☐ Not done

Culture: ☐ Neg. ☐ Pos. ☐ Pending ☐ Not done

VI. PATHOLOGY: ☐ Pathology done, ☐ No pathology

Source:_____ Date Collected____/___/____

Results:_____

ATS Classification:___(0) No TB exposure, not infected ___(2) TB infection, no disease ___(4) Old TB disease, not current

___(1) TB exposure, not infected ___(3) Active TB disease, current ___(5) Suspect, diagnosis pending

Disease Site (Class 3 or 5) ____ Pulmonary ____ Extrapulmonary

VIII. Baseline Tests: **Liver Profile:** ☐ Not done ☐ Wnl. ☐ Abn. _____ ☐ Attached

Eye Check for EMB: ☐ Not done ☐Wnl ☐Abn. _____

IX. PRESCRIBED MEDICATIONS:

Expected Duration of Therapy_____months.

DRUG	DOSAGE	FREQ	START DATE
Rifater			
Rifamate			
INH			
RIF			
PZA			
EMB			

☐**DOT :** ☐ **Daily** ☐ **Intermittent:**_____ **X/Week**

☐ Health Dept. ☐ Home ☐Other _____

☐ **Case/Suspect Reported to WVTB Control**

1-800-330-8126

X. PLAN

☐ **Reason Treatment of Latent TB Infection not recommended:**

☐ Abn. LFT; ☐ Pregnant- Return after Delivery; ☐ Previous Tx.;

☐ Other _____.

☐ **Patient Declined Treatment of LTBI**

☐ **Discharged from Clinic/No further Follow-Up Recommended**

Patient Education:

☐ TB Infection vs. disease explained ☐ S/S of disease

☐ Medication risks/benefits explained ☐ Importance of taking meds.

☐ Importance of keeping appointments ☐ Literature given to patient

Tests

☐ Sputums Ordered_____ ☐ Repeat. CXR_____

☐ Repeat LFT_____ ☐ Other _____

Next Visit: ____/____/_____ ☐ Interpreter needed_____

COMMENTS:_____

Signature:☐ M.D._____ Signature:☐ R.N._____

TB-N-17

West Virginia Department of Health and Human Services

SUBSEQUENT VISITS TO CLINIC

Date_____ Weight_____ Sputum_____	Report:____ X-ray; ____ Dx Clinic; ____ Nurse Assessment Sign:_____
Date_____ Weight_____ Sputum_____	Report:____ X-ray; ____ Dx Clinic; ____ Nurse Assessment Sign:_____
Date_____ Weight_____ Sputum_____	Report:____ X-ray; ____ Dx Clinic; ____ Nurse Assessment Sign:_____
Date_____ Weight_____ Sputum_____	Report:____ X-ray; ____ Dx Clinic; ____ Nurse Assessment Sign:_____

TB-N17-S

West Virginia Department of Health and Human Resources
TUBERCULOSIS CONTROL PROGRAM
MEDICATION INVENTORY

COUNTY_____ DATE:_____

Medication	Dosage	Size Bottle	Amount on Hand	Expiration Date
(INH) Isoniazid	300 mg	100 tabs / btl		
(INH) Isoniazid	300 mg	1000 tabs / btl		
(INH) Isoniazid	100 mg	100 tabs / btl		
(INH) Isoniazid	50 mg/ 5 cc	16 oz. (1 pint)		
(RIF) Rifampin	300 mg	60 tabs / btl		
(RIF) Rifampin	150 mg	30 tabs / btl		
(PZA) Pyrazinamide	500 mg	100 tabs / btl		
(EMB) Myambutol	400 mg	100 tabs / btl		
(EMB) Myambutol	100 mg	100 tabs / btl		
(B6) Pyridoxine	50 mg	100 tabs / btl		
BIAXIN (Clarithromycin)	500 mg	60 tabs / btl		
CIPRO	500 MG	100 tabs / btl		
PPD (Purified Protein Derivative)		10 dose vial		
PPD (Purified Protein Derivative)		50 dose vial		
SYRINGES 27 gauge	1/2", 1cc	100 / box		
CAPES				
Pill Bottles				

Inventory performed by:

PATIENT'S NAME _____ **ADDRESS** _____

____ **INH** Date Started _____ Dosage _____ Date Terminated _____

____ **RIF** Date Started _____ Dosage _____ Date Terminated _____

____ **PZA** Date Started _____ Dosage _____ Date Terminated _____

____ **EMB** Date Started _____ Dosage _____ Date Terminated _____

____ ____ Date Started _____ Dosage _____ Date Terminated _____

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
INH												
RIF												
PZA												
EMB												

TB-50 (Revised 2/95)

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH

Individual Record of Tuberculin Test

NAME _____

ADDRESS _____

BIRTHDATE _____ SEX _____

PPD _____ Neg. _____ Pos. _____ mm

DATE _____ _____
Health Officer

TB-60 (Revised 9/04)

_____Health Department
_____
_____

TO:_____ DATE:_____
_____ Re:_____
_____ _____

Dear Doctor:

The above-named case, contact, or suspected case of tuberculosis is understood to be under you care. The information requested below is needed to assist in surveillance and containment of the diseae. Would you please complete the form and return it to the Health Department? Thank you for your assistance.

_____
HEALTH OFFICER

Please supply information as indicated.

1. Date of last medical examination:_____. Is patient still under your care: ____YES ____NO

2. Date of last chest x-ray:_____. Results_____

3. Tuberculin test status: DATE:_____. Type of test: MANTOUX:_____ MULTIPUNCTURE_____
   RESULTS:_____

4. Last bacteriological examination: Date collected:_____
   Type: ____Sputum Method: ____Spontaneous RESULTS: SMEAR CULTURE
   ____Other (specify) ____Induced ____Positive ____Positive for MTB
   _____ ____Other (specify) ____Negative ____Positive(atypical)
   _____ ____Negative
   ____Pending

   DATE OF SPUTUM CONVERSION TO NEGATIVE:_____

   Date of last positive bacteriological examination:_____

5. Drug susceptibilities/Sensitivites done? ____Yes ____No Date of specimen collection_____
   Susceptibility results:_____

6. Present diagnosis:
   A. Tuberculosis disease: Site: ___Pulmonary ___Genitourinary ___Lymphatic ___Bone/Joint
   ___Meningeal ___Peritoneal ___Pleural ___Miliary
   ___Other (specify)_____
   B. Tuberculin infection.
   C. Suspect - diagnosis pending
   D. Mycobacterium Other Than Tuberculosis (MOTT) Specify_____
   E. Other (specify_____

7. Treatment: On TB drugs? ___Yes ___No Date started_____ Date Completed_____

DRUG	DOSAGE
___INH	_____
___RIFAMPIN	_____
___PZA	_____
___EMB	_____
___Other (specify)	
_____	_____

8. Remarks & recommendations:_____

TB-70 Signed_____ Date:_____

TUBERCULOSIS RECORD

DOH Facility Code ____ 9 Digit Medical Record # _____ Referred by _____

Last name _____ First _____ Middle Initial _____ Date of birth ____/____/____ Age ____

Telephone (____) _____ Address _____
street city state zip code

☐ NO ACTION ☐ START ☐ STOP ☐ CHANGE ☐ RESTART ☐ SUSPICION OF ACTIVE TB

Sex	Race	Ethnicity	Reason for Testing	Residence	Country of Birth
☐ male ☐ female	☐ white ☐ Asian or Pacific Islander ☐ Black ☐ American Indian ☐ Other _____	☐ Hispanic ☐ non-Hispanic ☐ unknown	screening ☐ low risk ☐ high risk ☐ work requirement ☐ symptoms/diagnostic ☐ contact to TB case ☐ migrant worker ☐ immigrant/refugee	☐ private residence ☐ homeless ☐ shelter ☐ jail/ prison ☐ nursing home ☐ treatment center.	☐ United States ☐ other (specify) _____ If other, date of entry to US: ____/____/____

MEDICAL HISTORY

Diabetes	Chemical Use	HIV status	Lung disease	G.I./G.U.	Cancer/ chemotherapy	Hepatitis	Medications
☐ none known ☐ diet only ☐ oral medications ☐ insulin ☐ uncontrolled	☐ none known ☐ injected drug use ☐ other drug use ☐ excess alcohol ☐ > 2 drinks/day ☐ binge drinking ☐ current tobacco use amount _____	☐ unknown ☐ negative ☐ positive date: _____ test offered: ☐ yes ☐ no	☐ none known ☐ asthma ☐ silicosis ☐ pneumonia ☐ other _____	☐ none known ☐ gastrectomy ☐ intestinal bypass ☐ pregnancy EDD:___/___/___ ☐ post-partum ☐ end stage renal disease	☐ none known ☐ leukemia/ lymphomas/ malignancies ☐ immunosuppressive therapy ☐ other _____	☐ none known ☐ Hep A ☐ Hep B ☐ Hep C ☐ unknown type	☐ none known ☐ steroids ☐ anticonvulsants ☐ tranquilizers ☐ birth control ☐ anticoagulants ☐ other _____ ☐ Allergies: ____ _____

CLINICAL STATUS

Prior TB Therapy	Symptoms	Skin Test Results	Chest Xray
☐ None ☐ Post Preventive Therapy (PT) ☐ Partial PT ☐ Undergoing PT ☐ Post BCG: year: _____ ☐ Multi-drug therapy for active TB year: _____	☐ none ☐ productive cough ☐ hemoptysis ☐ shortness of breath ☐ weight loss ☐ night sweats ☐ fever ☐ malaise ☐ other _____ Current wt: _____ lbs.	PPD #1 Date:___/___/___ Reading _____mm PPD #2 Date:___/___/___ Reading _____mm Known positive reactor: _____mm Year: _____ Last known negative test ___/___/___	Date: ____/____/____ ☐ Normal ☐ within normal limits ☐ abnormality limited to calcified granuloma(s) ☐ Abnormal ☐ possible primary pulmonary TB (i.e. hilar adenopathy) ☐ evidence of old inactive TB ☐ suspect active tuberculosis ☐ Other _____ Please send all abnormal CXR's to the TB Program

PREVENTIVE THERAPY

Reasons for Preventive Therapy	Anti-tuberculosis Drugs	Duration	Preventive therapy	Contact Investigation/Index Case (if known)
☐ contact, recent ☐ reactor ☐ convertor ☐ old TB disease ☐ other high risk	☐ Isoniazid ☐ Rifampin ☐ PZA ☐ other _____ _____	☐ 2 months ☐ 4 months ☐ 6 months ☐ 9 months ☐ 12 months	Start date: ___/___/___ Anticipated start date: ___/___/___ ☐ not recommended (comment below) ☐ refused Signature: _____ Date: _____	Last name _____ First name _____ DOB: ___/___/___ Date TB diagnosed: _____ Smear results _____neg _____pos

*COMMENTS/RECOMMENDATIONS _____

STOPPED PREVENTIVE THERAPY	Length of Therapy	Tuberculosis Classification (for TB Program use only)
☐ Completed therapy ☐ Refused ☐ Active TB ☐ Moved ☐ Adverse Reaction ☐ Lost ☐ Died ☐ Not infected ☐ Other _____	Stop Date:___/___/___ Months on therapy _____ Reported by: _____ Date ___/___/___	☐ 0 Not exposed, not infected ☐ 1 Exposed, not infected ☐ 2 Infected, no current disease ☐ 3 Active TB_____ pulmonary _____ extrapulmonary ☐ 4 Inactive tuberculosis ☐ 5 TB suspect ☐ 6 MOTT _____ ☐ 7 Unclassified/insufficient data

(Rev 4/

TB-101