Figure: 25 TAC §97.179(c)

TUBERCULOSIS RECORD

Certificate □ Tuberculosis History Record □ Record of Transfer □ Date of Transfer

A. IDENTIFICATION

Facility Name	Address		Medical Section Phone	
□ Inmate	□ Employee		□ Volunteer	
(Last Name)	(First Name)	(Middle)	AKA (Last)	(First)
Date of Incarceration/Employment/Entry:		Cell number or work location:		
Social Security Number:	ID Number:	Sex: □ Male □ Female		
Phone # ( )	Home Street Address City	State	Zip	
DOB:	County of Birth	Race (check all that apply): □ White □ Black or African American □ Asian □ Native Hawaiian or Pacific Islander □ American Indian or Alaskan Native □ Unknown		
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown				

B. TUBERCULIN SKIN TEST (TST) HISTORY

Initial Skin Test (or Documented History of Positive PPD)

Date Given: Date Read: Size: mm

TST Date: Size: mm	TST Date: Size: mm
TST Date: Size: mm	TST Date: Size: mm

C. ACTIONS TAKEN FOR FURTHER EVALUATION AND/OR TREATMENT

Chest X-ray Date: Results: □ Normal □ Abnormal □ Not Done □ UNK

History of previous TB treatment?

□ Latent TB Infection Start Date:_____ Stop Date:_____
□ TB Disease Start Date:_____ Stop Date:_____

HIV Test:
Date:_____ □ Positive □ Negative
If not done, give reason

Diagnosis Date:

□ Active TB □ Latent TB Infection

For Active TB:
Predominant Site:
□ Pulmonary □ Other (specify)_____

CURRENT TREATMENT
Regimen Started_____/_____/____ Regimen Stop____/____/____

□ INH
□ RIF
□ PZA
□ EMB

Other_____
□ DOT □ Self-administered

Reason Stopped:

Drug Resistance? □ No □ Yes

Case reported to Health Department?
□ Yes □ No

Date of Report to Health Department:
(MM/DD/YYYY):_____

Contact Investigation done? □ Yes □ No
If yes,

Patient Interview Date:_____

Follow-up Date:_____

D. SIGNATURE OF PHYSICIAN OR INDIVIDUAL COMPLETING THIS RECORD

/ /

(Signature) (Title) (Date)

COMMENTS