DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-02474 (03/2019)

STATE OF WISCONSIN
Wisconsin Tuberculosis Program
608-261-6319

ACTIVE TUBERCULOSIS (TB) DISEASE FOLLOW-UP REPORT

Local Health Department and Address

Fill out this form when a client has completed therapy for active tuberculosis disease or discontinues treatment.

Return this form to the local health department in which the client resides or upload to WEDSS.

For information, contact the Wisconsin TB Program at 608-261-6319.

Client Name – Last, First, Middle Initial	Date of Birth (mm/dd/yyyy)

Client Address – Street, City and Zip code

Test for Infection (Check all that apply)

IGRA (Quantiferon or TSPOT) interpretation	Tuberculin Skin Test Interpretation
☐ Positive ☐ Negative ☐ Indeterminate ☐ Borderline	☐ Positive ☐ Negative

Chest Imaging Results (Check all that apply)

Initial ☐ Normal ☐ Abnormal	If abnormal ☐ Cavitary ☐ Milliary ☐ Other _____
After two months of treatment ☐ Normal ☐ Abnormal	If abnormal ☐ Cavitary ☐ Milliary ☐ Other: _____
After completion of treatment ☐ Normal ☐ Abnormal	If abnormal ☐ Cavitary ☐ Milliary ☐ Other: _____

Microbiology

Microbiology confirmed TB case? ☐ Yes ☐ No	If yes, confirmed by (Check all that apply ☐ Culture ☐ Molecular test (PCR, GeneXpert)
Drug susceptibility testing performed? ☐ Yes ☐ No	If yes, the testing showed: ☐ Complete susceptibility ☐ Resistance to: ☐ Isoniazid ☐ Rifampin ☐ Ethambutol ☐ Pyrazinamide

Date of culture conversion

Disease Site

☐ Pulmonary ☐ Extrapulmonary, Specify: _____

Active Tuberculosis Treatment

Directly observed therapy?

☐ Yes ☐ No

Medication start date: _____

Medication stop date: _____

Initial regimen:

☐ 2 months of Isoniazid, Rifampin, Pyrazinamide, Ethambutol

☐ Other _____

Followed by:

☐ 4 months Isoniazid and Rifampin

☐ 7 months Isoniazid and Rifampin

☐ Other: _____

Disposition

Did the patient complete an adequate treatment regimen?

☐ Yes ☐ No

If No, select reason:

☐ Death

☐ Adverse effect of medicine

☐ Provider decision

☐ Patient moved (follow-up unknown)

☐ Patient lost to follow-up

☐ Active disease ruled out

SERVICE PROVIDER INFORMATION

Provider – Name	Assessment Date
Facility Name	Phone No.
Street Address (City State, Zip Code)	
SIGNATURE – Provider	Date Signed

Clear/Reset Entire Form