

Medical Consultation Form

**** Please attach any reports (bacteriology, susceptibilities, Xpert, MDDR) that will aid our consultants in the recommendation process ****

Date:

Patient Name & DOB:

Patient weight (kg):

Patient medical history:

Current problem:

TB risk factors:

TB signs/symptoms: (date of onset and current status of symptoms)

Imaging: CXR/CT

| Date of Imaging | Type of Imaging | Impression/Report |
|-----------------|-----------------|-------------------|
| | | |
| | | |
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| | | |
| | | |

Labs:

| | | | | | | |
|------------------|--|--|--|--|--|--|
| Date: | | | | | | |
| TST | | | | | | |
| QFT | | | | | | |
| T-Spot | | | | | | |
| AST (SGOT) | | | | | | |
| ALT (SGPT) | | | | | | |
| TBili | | | | | | |
| Alk. Phos | | | | | | |
| BUN | | | | | | |
| Serum Creatinine | | | | | | |

| | | | | | | |
|------------|--|--|--|--|--|--|
| Hgb/Hct | | | | | | |
| WBC | | | | | | |
| Plt | | | | | | |
| TSH | | | | | | |
| HgbA1C | | | | | | |
| HIV | | | | | | |
| CD4 | | | | | | |
| Viral Load | | | | | | |

Additional labs:

TB Medication Summary (if applicable):

| DATE started | Medication | Dosage | # doses received (please indicated # of DOT, VDOT, or Self admin. | | |
|--------------|------------|--------|---|------|-----|
| | | | DOT | VDOT | SAT |
| | | | DOT | VDOT | SAT |
| | | | DOT | VDOT | SAT |
| | | | DOT | VDOT | SAT |
| | | | DOT | VDOT | SAT |

Bacteriology:

| Date | Smear | HPLC/NAA/PCR | Culture | Comments |
|------|-------|--------------|---------|----------|
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Reason for Consult (*question*) and *most recent* clinical evaluation of Patient: