

ADHS PREVENTION REGISTRY FORM

DEMOGRAPHICS

Date Entered into Registry: ___/___/___ Provider Code ___ Local ID/ADC#: ___ Other ID: ___ County: _____

Last Name: _____ First Name: _____ Initial _____

Date of Birth: ___/___/___

Date Reported to Public Health: ___/___/___

Street Address: _____	City: _____	State: _____	ZIP Code: _____
Telephone: Home () _____	Work: () _____	Other: () _____	
Mailing Address (if different than Street Address): _____	City: _____	State: _____	ZIP Code: _____

Sex at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Race (select one or more): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian, <i>Specify</i> _____ <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <i>Specify</i> _____ <input type="checkbox"/> White	Ethnicity (select one): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Country of Birth: <input type="checkbox"/> United States <input type="checkbox"/> Mexico <input type="checkbox"/> Other _____ Date Entered U.S. ___/___/___	Reason For Evaluation: <input type="checkbox"/> Contact Investigation <input type="checkbox"/> Symptoms/Diagnostic <input type="checkbox"/> Targeted Testing <input type="checkbox"/> Immigrant/Refugee <input type="checkbox"/> Day Care/School <input type="checkbox"/> Employment
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RISK FACTORS

HIV Status: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Refused <input type="checkbox"/> Not Offered <input type="checkbox"/> Test Done, Result Unknown <input type="checkbox"/> Unknown	Residence: <input type="checkbox"/> Homeless/Shelter <input type="checkbox"/> Correctional Facility <i>Type of Facility:</i> <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> Local <input type="checkbox"/> Juvenile <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Nursing Home / Long Term Care <input type="checkbox"/> Treatment Center <input type="checkbox"/> Other _____	Substance Use (past year): <input type="checkbox"/> None Known <input type="checkbox"/> Injecting Drug Use <input type="checkbox"/> Non-Injecting Drug Use <input type="checkbox"/> Excess Alcohol	Primary Occupation (past year): <input type="checkbox"/> Health Care Worker <input type="checkbox"/> Migrant/Seasonal Worker <input type="checkbox"/> Retired <input type="checkbox"/> Not Seeking Employment (student, homemaker, disabled person) <input type="checkbox"/> Correctional Facility Employee <input type="checkbox"/> Other Occupation <input type="checkbox"/> Unemployed <input type="checkbox"/> Unknown	Additional Risk Factors: <input type="checkbox"/> None <input type="checkbox"/> Contact of MDR-TB Patient (2 years or less) <input type="checkbox"/> Contact of Infectious TB Patient (2 years or less) <input type="checkbox"/> Missed Contact (2 years or less) <input type="checkbox"/> Incomplete LTBI Therapy <input type="checkbox"/> Post-organ Transplantation <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> TNF- α Antagonist Therapy <input type="checkbox"/> End-Stage Renal Disease <input type="checkbox"/> Immunosuppression (not HIV/AIDS) <input type="checkbox"/> Other
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CURRENT CLINICAL STATUS

TB History (select all that apply): <input type="checkbox"/> None Known <input type="checkbox"/> Complete LTBI therapy <input type="checkbox"/> Incomplete LTBI therapy <input type="checkbox"/> Active TB Year _____ <input type="checkbox"/> Complete TB therapy <input type="checkbox"/> Incomplete TB therapy <input type="checkbox"/> History of BCG Year _____	Symptoms (select all that apply): <input type="checkbox"/> None <input type="checkbox"/> Productive Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Weight Loss <input type="checkbox"/> Night Sweats <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Fever <input type="checkbox"/> Other _____	Screening: Date TST1 placed ___/___/___ Date TST1 read ___/___/___ Reading _____ mm Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown Date TST2 placed ___/___/___ Date TST2 read ___/___/___ Reading _____ mm Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown Known Positive Reactor: <input type="checkbox"/> Yes <input type="checkbox"/> No Date ___/___/___ Result _____ mm IGRA Testing: Date Collected ___/___/___ Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown <input type="checkbox"/> Not Done	Diagnostic Imaging: Date ___/___/___ Type: <input type="checkbox"/> Chest radiograph <input type="checkbox"/> Chest CT scan Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (consistent with TB) <input type="checkbox"/> Evidence of a cavity <input type="checkbox"/> Evidence of miliary TB <input type="checkbox"/> Not Done/Refused <input type="checkbox"/> Unknown Additional: Date ___/___/___ Type: <input type="checkbox"/> Chest radiograph <input type="checkbox"/> Chest CT scan Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (consistent with TB) <input type="checkbox"/> Evidence of a cavity <input type="checkbox"/> Evidence of miliary TB <input type="checkbox"/> Not Done/Refused <input type="checkbox"/> Unknown	Laboratory Tests: Specimen type: _____ <u>Date Collected</u> _____ <u>AFB Smear</u> _____ <u>MTB Culture</u> _____ 1) ___/___/___ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown <u>Date Reported</u> _____ 1) ___/___/___ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown Specimen type: _____ <u>Date Collected</u> _____ <u>AFB Smear</u> _____ <u>MTB Culture</u> _____ 2) ___/___/___ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown <u>Date Reported</u> _____ 2) ___/___/___ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown Specimen type: _____ <u>Date Collected</u> _____ <u>AFB Smear</u> _____ <u>MTB Culture</u> _____ 3) ___/___/___ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown <u>Date Reported</u> _____ 3) ___/___/___ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
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