TEXAS
Health and Human Services

Texas Department of State Health Services

Jennifer A. Shuford, M.D., M.P.H.
Commissioner

Tuberculosis Infection is now a reportable condition in the state of Texas.

LTBI is diagnosed based upon the following findings:

1. A positive Tuberculin skin test (TST) or positive blood test (IGRA).
2. A CXR that shows no evidence of active Tuberculosis (TB) disease.
3. No symptoms or physical findings suggestive of TB disease.

If you have diagnosed a patient with LTBI, please fax the following information to the Texas Department of State Health Services (DSHS) within 5 working days:

1. The TB 400A form, to include-
    a. Signature of the provider who diagnosed the patient with LTBI or who will provide LTBI treatment for the patient.
    b. Documented result of the TST or IGRA when positive (for TST include the numeric mm read).
2. CXR results (or CT results) that show no evidence of active TB disease.
3. Documentation that the patient does NOT have any signs or symptoms of TB disease (fevers, chills, cough, productive cough, hemoptysis, night sweats, weight loss, fatigue).

NOTE: The bottom section of the TB400A has a treatment section describing which medication is prescribed. If medication is started, the TB400A can be faxed at initiation of treatment and again at the end of treatment to include the closure date and months on treatment. **If patient declines treatment, fax the TB400A at diagnosis and include reason why closure was made before treatment was completed.**

FAX NUMBER:	**512-206-3949**
PHONE NUMBER:	210-949-2000
ADDRESS:	Texas Department of State Health Services, Region 8 7430 Louis Pasteur San Antonio, TX 78229

For additional information, please see the following websites:

For LTBI information and treatment options: http://www.cdc.gov/tb/publications/ltbi/default.htm
For screening, diagnosis, and treatment of LTBI in primary care settings (**with tips on coding and billing for LTBI services**): Heartland National TB Center Reference Document
For disease reporting: Reporting Forms | Texas DSHS

If you have any questions, please do not hesitate to contact our office.

Sincerely,

Lillian Ringsdorf, MD, MPH
Medical Director
Texas Department of State Health Services, Public Health Region 8

SAVE PRINT CLEAR

TEXAS Health and Human Services | Texas Department of State Health Services

TB-400A

Report of Case and Patient Services

Date reported to health department _____
Date form sent to PHR _____
Date form sent to central office _____

☐ Initial Report ☐ Hospital Admission
☐ Address Change ☐ Name Change (show new name and draw single line through old) ☐ Other Change

SSN _____ Medicaid # _____ ID# _____ DOB _____

Name _____ (Last) _____ (First) _____ (Middle) _____ (Alias)

_____ Street _____ Apt# _____ City _____ County _____ Zip Code _____ Patient's Tel.#

Facility/Care Provider Name _____ Name of person completing this form _____

Initial Reporting Source ☐ Health Dept ☐ Private Physician ☐ Public Hospital ☐ VA Hospital ☐ Military Hospital ☐ TDCJ ☐ Other (Specify): _____

Country of Birth _____
Date of U.S. Entry (if foreign born) _____
Eligible for U.S. Citizenship/ Nationality at Birth? _____
Preferred Language _____

Notice of Arrival of Alien with TB Class
☐ A ☐ B1 ☐ B2 ☐ B3

Reported at Death
☐ Yes ☐ No
Death date _____
Was TB cause of death?
☐ Yes ☐ No ☐ Unk

Reported Out of State or Country
☐ Yes (specify): _____ ☐ No

ETHNICITY ☐ Unknown
☐ Hispanic or Latino
☐ Not Hispanic or Latino

SEX
☐ Male
☐ Female

RACE (check all that apply)
☐ White
☐ Black or African American
☐ Asian
☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaskan Native
☐ Unknown

OCCUPATION (within past 2 years)
☐ Employed (If employed, check all that apply) ☐ Unemployed during last 2 yrs ☐ Unknown
☐ Health Care Worker (specify): _____
☐ Migrant/Seasonal Worker
☐ Correctional Employee
☐ Other Occupation (specify): _____

Initial Reason Evaluated for TB
☐ Contact Investigation ☐ Screening ☐ TB Symptoms ☐ Other, specify: _____

Resident of Correctional Facility at Time of Dx ☐ Yes ☐ No ☐ Unknown Incarceration Date _____
If Yes ☐ Federal Prison ☐ State Prison ☐ County Jail ☐ City Jail ☐ Juvenile Correctional Facility ☐ ICE ☐ Other

Resident of Long Term Care Facility at Time of Dx ☐ Yes ☐ No ☐ Unknown
If Yes ☐ Nursing Home ☐ Hospital-Based Facility ☐ Residential Facility ☐ Mental Health Residential Facility
☐ Alcohol/Drug Treatment Facility ☐ Other Long Term Care Facility

POPULATION RISKS
☐ Low Income
☐ Inner-city resident
☐ Foreign born
☐ Binational (US-Mexico)
* **Within past 2 years**
☐ Correctional employee*
☐ Health care worker*
☐ Prison/Jail inmate*
☐ Long-term care facility*
☐ Health care facility/resident*
☐ Homeless in past 12 months
☐ Homeless ever
☐ Migrant farm worker*
☐ None of the above risks apply

MEDICAL RISKS
☐ Diabetes mellitus
☐ Alcohol Abuse (within past year)
☐ Tobacco use: _____
☐ Silicosis
☐ Immunosuppressive therapy
☐ TNF-α antagonist therapy
☐ Gastrectomy or jejunoileal bypass
☐ Age ≤ 5 years
☐ Recent exposure to TB (Contact to TB case)
☐ Contact to MDR-TB case
☐ Weight at least 10% less than ideal body weight
☐ Chronic malabsorption syndromes
☐ Leukemia
☐ Lymphoma
☐ Cancer of head
☐ Cancer of neck
☐ Drug abuse within past year:
  ☐ Injecting
  ☐ Non-injecting
  ☐ Unknown if injecting
☐ HIV seropositive (only if laboratory confirmed)
☐ TST/IGRA conversion within 2 years
☐ Fibrotic lesions (on chest x-ray) consistent with old, healed TB
☐ End stage renal disease
☐ Organ Transplant
☐ Other: _____
☐ None of these medical risks apply

HIV TEST RESULTS
Test Date _____
☐ Positive ☐ Negative
☐ Pending ☐ Refused
☐ Not Offered
Date CD4 Count _____
Results CD4 Count _____

☐ **TB Skin Test** ☐ **IGRA** Documented history of positive TST or IGRA? ☐ Yes ☐ No

Date _____ _____ mm ☐ Positive ☐ Negative ☐ Not read/indeterminate/borderline

Date _____ _____ mm ☐ Positive ☐ Negative ☐ Not read/indeterminate/borderline

PRIOR LTBI TREATMENT ☐ Yes ☐ No
Start Date _____
Stop Date _____

ATS Classification
☐ 0 No M. TB Exposure, Not TB Infected
☐ 1 M. TB Exposure, No Evidence of TB Infection
☐ 2 M. TB Infection, No Disease
☐ 4 M. TB, No Current Disease

FOR TREATMENT OF LTBI ONLY Date Normal Chest X-ray: _____

DOPT: ☐ Yes, totally observed ☐ No, self-administered
DOPT Site: ☐ Clinic or medical facility ☐ Field ☐ VDOT
Frequency: ☐ Daily ☐ Once Weekly ☐ Twice Weekly

Regimen Start Date _____ Stop Date _____ Weight _____
Regimen Restart Date _____ Stop Date _____ Height _____

☐ Isoniazid _____ mgs ☐ B6 _____ mgs
☐ Rifampin _____ mgs ☐ Other (specify): _____ _____ mgs
☐ Rifapentine _____ mgs Prescribed for: _____ months Maximum refills authorized: _____

General Comments:

_____ Physician Signature _____ Date

CLOSURE: Date _____
☐ Lost to follow-up ☐ Patient chose to stop
☐ Adverse drug reaction
Provider decision: ☐ Pregnant ☐ Non-TB
☐ Completion adequate therapy ____ # months on Rx ____ # months recommended
☐ Deceased (Cause): _____
☐ Moved out of state/country to: _____
☐ Other: _____