

**OKLAHOMA DEPARTMENT OF CORRECTIONS  
TUBERCULOSIS SUMMARY RECORD**

( ) OPENING INTERCHANGE  
DATE: \_\_\_\_\_

( ) CLOSING INTERCHANGE  
DATE: \_\_\_\_\_

( ) UPDATE INTERCHANGE  
DATE: \_\_\_\_\_

|                               |   |                               |             |
|-------------------------------|---|-------------------------------|-------------|
| <b>NAME:</b><br>(Last, First) | Date of Reception: ____/____/____<br>Date of Employment: ____/____/____ | SS Number:<br>_____-____-____ | DOC Number: |
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|  |   |
|--|---|
| <input type="checkbox"/> Inmate<br><input type="checkbox"/> Employee | Home Address: _____ County of Residence: _____<br>City/State/Zip: _____ Phone: (____) _____ |
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|   |  |  |
|---|--|--|
| <b>DOB:</b> ____/____/____<br>SEX: <input type="checkbox"/> Female <input type="checkbox"/> Male<br>Country of Birth: _____ | <b>RACE:</b><br><input type="checkbox"/> White <input type="checkbox"/> Amer. Ind./Alaskan Native <input type="checkbox"/> Black<br><input type="checkbox"/> Asian or Pacific Islander | <b>ETHNIC ORIGIN:</b><br><input type="checkbox"/> Hispanic/Latino<br><input type="checkbox"/> Non Hispanic |
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| <b>BASELINE TESTING INITIAL SKIN TEST:</b><br>(or Documented History of Positive Mantoux)<br><b>Was therapy recommended?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No | Date Given: ____/____/____<br>Date Read: ____/____/____<br>SIZE _____mm | <b>BOOSTED SKIN TEST:</b><br>Date Given: ____/____/____<br>Date Read: ____/____/____<br>SIZE _____mm |
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|   |  |
|---|--|
| Classification:<br><input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4<br><input type="checkbox"/> 5 | Have you ever had an organ transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Are you on medications that suppress your immune system? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|

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|---|---|---|
| <b>CXR</b><br>DATE ____/____/____<br><input type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal | <b>IF ABNORMAL:</b><br><input type="checkbox"/> Cavitory <input type="checkbox"/> Stable<br><input type="checkbox"/> Non Cavitory<br><input type="checkbox"/> Worsening | <b>HISTORY OF PREVIOUS TB TREATMENT:</b><br><input type="checkbox"/> INFECTION-Date started: _____ Date stopped: _____<br><input type="checkbox"/> TB DISEASE-Date started: _____ Date stopped: _____ |
|---|---|---|

| <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:15%;"></th> <th style="width:15%;"></th> <th style="width:10%;">POS</th> <th style="width:10%;">NEG</th> <th style="width:10%;">Date</th> <th style="width:10%;">Source</th> </tr> </thead> <tbody> <tr> <td rowspan="4"><b>Bacteriology For M. Tuberculosis:</b></td> <td>AFB Smear</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Collected</td> <td>_____</td> </tr> <tr> <td>Culture</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> <td>_____</td> </tr> <tr> <td>AFB Smear</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Collected</td> <td>_____</td> </tr> <tr> <td>Culture</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> <td>_____</td> </tr> <tr> <td>AFB Smear</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Collected</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Culture</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> |                          |                          | POS                      | NEG       | Date   | Source | <b>Bacteriology For M. Tuberculosis:</b> | AFB Smear | <input type="checkbox"/> | <input type="checkbox"/> | Collected | _____ | Culture | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | AFB Smear | <input type="checkbox"/> | <input type="checkbox"/> | Collected | _____ | Culture | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | AFB Smear | <input type="checkbox"/> | <input type="checkbox"/> | Collected | _____ | _____ | Culture | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | _____ | <b>DIAGNOSIS DATE:</b> ____/____/____ Weight: _____<br><input type="checkbox"/> Active TB <input type="checkbox"/> TB Infection w/o disease<br><br><b>FOR ACTIVE TB:</b><br>Major Site of Disease<br><input type="checkbox"/> Pulmonary <input type="checkbox"/> Other (specify) _____<br>Case reported to Health Department? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Date of Report: ____/____/____<br>Contact Investigation done? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, Date ____/____/____ Follow-up Date ____/____/____ |
|--|--------------------------|--------------------------|--------------------------|-----------|--------|--------|--|-----------|--------------------------|--------------------------|-----------|-------|---------|--------------------------|--------------------------|-------|-------|-----------|--------------------------|--------------------------|-----------|-------|---------|--------------------------|--------------------------|-------|-------|-----------|--------------------------|--------------------------|-----------|-------|-------|---------|--------------------------|--------------------------|-------|-------|-------|---|
|  |                          | POS                      | NEG                      | Date      | Source |        |  |           |                          |                          |           |       |         |                          |                          |       |       |           |                          |                          |           |       |         |                          |                          |       |       |           |                          |                          |           |       |       |         |                          |                          |       |       |       |   |
| <b>Bacteriology For M. Tuberculosis:</b>   | AFB Smear                | <input type="checkbox"/> | <input type="checkbox"/> | Collected | _____  |        |  |           |                          |                          |           |       |         |                          |                          |       |       |           |                          |                          |           |       |         |                          |                          |       |       |           |                          |                          |           |       |       |         |                          |                          |       |       |       |   |
|  | Culture                  | <input type="checkbox"/> | <input type="checkbox"/> | _____     | _____  |        |  |           |                          |                          |           |       |         |                          |                          |       |       |           |                          |                          |           |       |         |                          |                          |       |       |           |                          |                          |           |       |       |         |                          |                          |       |       |       |   |
|  | AFB Smear                | <input type="checkbox"/> | <input type="checkbox"/> | Collected | _____  |        |  |           |                          |                          |           |       |         |                          |                          |       |       |           |                          |                          |           |       |         |                          |                          |       |       |           |                          |                          |           |       |       |         |                          |                          |       |       |       |   |
|  | Culture                  | <input type="checkbox"/> | <input type="checkbox"/> | _____     | _____  |        |  |           |                          |                          |           |       |         |                          |                          |       |       |           |                          |                          |           |       |         |                          |                          |       |       |           |                          |                          |           |       |       |         |                          |                          |       |       |       |   |
| AFB Smear  | <input type="checkbox"/> | <input type="checkbox"/> | Collected                | _____     | _____  |        |  |           |                          |                          |           |       |         |                          |                          |       |       |           |                          |                          |           |       |         |                          |                          |       |       |           |                          |                          |           |       |       |         |                          |                          |       |       |       |   |
| Culture  | <input type="checkbox"/> | <input type="checkbox"/> | _____                    | _____     | _____  |        |  |           |                          |                          |           |       |         |                          |                          |       |       |           |                          |                          |           |       |         |                          |                          |       |       |           |                          |                          |           |       |       |         |                          |                          |       |       |       |   |

| <b>CHEMOTHERAPY FOR INFECTION OR DISEASE</b><br><table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;">Drugs</th> <th style="width:10%;">Dosage</th> <th style="width:15%;">Date started</th> <th style="width:15%;">Date stopped</th> <th style="width:50%;">Reason stopped</th> </tr> </thead> <tbody> <tr> <td>INH</td> <td>_____</td> <td>____/____/____</td> <td>____/____/____</td> <td>_____</td> </tr> <tr> <td>PZA</td> <td>_____</td> <td>____/____/____</td> <td>____/____/____</td> <td>_____</td> </tr> <tr> <td>RIF</td> <td>_____</td> <td>____/____/____</td> <td>____/____/____</td> <td>_____</td> </tr> <tr> <td>EMB</td> <td>_____</td> <td>____/____/____</td> <td>____/____/____</td> <td>_____</td> </tr> <tr> <td>Other</td> <td>_____</td> <td>____/____/____</td> <td>____/____/____</td> <td>_____</td> </tr> </tbody> </table> Drug resistance: <input type="checkbox"/> Yes <input type="checkbox"/> No Supervised by: _____<br>_____<br>If no chemotherapy given, reason: _____ | Drugs  | Dosage         | Date started   | Date stopped   | Reason stopped | INH | _____ | ____/____/____ | ____/____/____ | _____ | PZA | _____ | ____/____/____ | ____/____/____ | _____ | RIF | _____ | ____/____/____ | ____/____/____ | _____ | EMB | _____ | ____/____/____ | ____/____/____ | _____ | Other | _____ | ____/____/____ | ____/____/____ | _____ | <b>HIV TEST:</b><br>ELISA <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date _____<br>_____<br>W. Blot <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date _____<br>_____<br><b>TESTING:</b> Tetanus <input type="checkbox"/> Size: _____mm Date: ____/____/____<br>Other <input type="checkbox"/> Size: _____mm |
|---|--------|----------------|----------------|----------------|----------------|-----|-------|----------------|----------------|-------|-----|-------|----------------|----------------|-------|-----|-------|----------------|----------------|-------|-----|-------|----------------|----------------|-------|-------|-------|----------------|----------------|-------|---|
| Drugs   | Dosage | Date started   | Date stopped   | Reason stopped |                |     |       |                |                |       |     |       |                |                |       |     |       |                |                |       |     |       |                |                |       |       |       |                |                |       |   |
| INH   | _____  | ____/____/____ | ____/____/____ | _____          |                |     |       |                |                |       |     |       |                |                |       |     |       |                |                |       |     |       |                |                |       |       |       |                |                |       |   |
| PZA   | _____  | ____/____/____ | ____/____/____ | _____          |                |     |       |                |                |       |     |       |                |                |       |     |       |                |                |       |     |       |                |                |       |       |       |                |                |       |   |
| RIF   | _____  | ____/____/____ | ____/____/____ | _____          |                |     |       |                |                |       |     |       |                |                |       |     |       |                |                |       |     |       |                |                |       |       |       |                |                |       |   |
| EMB   | _____  | ____/____/____ | ____/____/____ | _____          |                |     |       |                |                |       |     |       |                |                |       |     |       |                |                |       |     |       |                |                |       |       |       |                |                |       |   |
| Other   | _____  | ____/____/____ | ____/____/____ | _____          |                |     |       |                |                |       |     |       |                |                |       |     |       |                |                |       |     |       |                |                |       |       |       |                |                |       |   |

| Date | Event/Comment | Date | Event/Comment |
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