Royal College of Nursing

Suspected TB case (Form: 1)

Form 1: Suspected TB Case (complete for every person referred for TB investigations). Clinic:

Hospital number: | Case manager: | Date referred to TB service: / / | Date 1st seen by TB service: / /

Last name: | First name: | Other names(AKA): | Designation:

Sex: M☐ F☐ | DOB: / / | Ethnicity: | Religion: | Country of birth: | Date/ Year of entry in the UK:

NHS no. | Occupation/ school details: | 1st language: | Needs interpreter: Yes ☐ No ☐

Address (usual place of residence or 'where can be found')

Telephone:

Next of kin/ parental responsibility (name and contact details)

GP details:(if registered)

Health Visitor:

School Nurse:

Other: (e.g. Clinic, RIO,CHAIN, HCU, MXU)

Route of presentation [AUDIT E]

1st seen by HCP / /

- ☐ Primary care (GP) [AUDIT A]
- ☐ Primary care (other)
- ☐ Secondary care
- ☐ TB Service
- ☐ Occupational Health
- ☐ A&E
- ☐ MXU
- ☐ Prison screening
- ☐ Port Health/ HPA
- ☐ Self referral

Reason for referral

- ☐ Symptomatic
- ☐ TB contact screening
- ☐ New entrant screening
- ☐ Transferred In TB Rx
- ☐ Anti TNF treatment
- ☐ BCG Vaccination
- ☐ Other (comments)

Symptoms [AUDIT E]

Date onset / /

- ☐ Weight loss (weight:_____)
- ☐ Lethargy
- ☐ Night sweats
- ☐ Fever
- ☐ Cough (dry)
- ☐ Cough (productive)
- ☐ Haemoptysis
- ☐ Dyspnoea
- ☐ Lymphadenopathy
- ☐ None
- ☐ Other (comments)

TB contact (index case details)

LTBR/name_____

Hospital number:_____

Relationship to index case : _____

Site of disease : _____

PT sputum smear: _____

PT culture: _____

Date diagnosed : _____

Initial assessment

* = enhanced case management to diagnosis (Dx) [AUDIT C]

- ☐ Previous TB diagnosis (year:_____)* (where:_____ for how long: _____)
- ☐ Previous TB prophylaxis (year:_____)
- ☐ Previous TB screening (year:_____ where: _____)
- ☐ Known TB contact (see box below)
- ☐ Current problem drug user*
- ☐ Problem drug use in last 5 years*
- ☐ Problem drug use > 5 years ago
- ☐ Alcohol misuse*
- ☐ Pregnant/ post partum
- ☐ Currently homeless*
- ☐ Homeless in the last 5 years*
- ☐ Homeless > 5 years ago
- ☐ Currently in prison*
- ☐ Prison in the last 5 years*
- ☐ Prison > 5 years ago
- ☐ Mental health history*
- ☐ BCG history
- ☐ BCG scar seen
- ☐ Recent travel to high risk area
- ☐ Immigration concerns

Notes - other TB risk factors and issues that may complicate diagnosis

Does this case require enhanced case management to diagnosis(any*)? Yes ☐ No ☐

TB Investigations :	Date	Results
☐ CXR	/ /	☐ CXR NAD
☐ Sputum 1: [AUDIT B] Smear: _____ Culture:_____	/ /	☐ CXR consistent with active TB
☐ Sputum 2: [AUDIT B] Smear: _____ Culture:_____	/ /	☐ CXR suggestive 'Old TB'
☐ Sputum 3: [AUDIT B] Smear: _____ Culture:_____	/ /	☐ CXR abnormal (not TB)
☐ Sputum (PCR)	/ /	☐ Sputum PCR +ive (any specimen)
☐ Induced or BAL	/ /	☐ Other culture +ive (e.g. pleural fluid) Site:_____
☐ FNA - Site: _____	/ /	☐ Histopathology suggestive of TB
☐ Biopsy - Site: _____	/ /	☐ QFT+/T Spot positive
☐ QFT/T Spot	/ /	☐ Blood tests normal
☐ CT	/ /	☐ Blood tests abnormal (comments)

Medical history/ medication/ screening summary

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☐	CT	/ /
☐	Routine Blood Tests	/ /
☐	Other (comments)	

Mantoux (1) **Date:** / / Live vaccine past 4/52 **Yes** ☐ **No** ☐

Batch Nr: _____ Expiry Date: _____

Signature: _____

Induration: _____ mm Site: _____

Read by: (signature) _____ Date: / /

Mantoux (2) **Date:** / / Live vaccine past 4/52 **Yes** ☐ **No** ☐

Batch Nr: _____ Expiry Date: _____

Signature: _____

Induration: _____ mm Site: _____

Read by: (signature) _____ Date: / /

Cont. Notes **Name:** **Hospital number:**

Recall for further investigations Date / /

Suspected TB case (Form: 1)

BCG **Date:** / /

Site: _____

Batch Nr: _____ Expiry Date: _____

Signature: _____

Diagnostic outcome Date / /	**Action**	**Audit**
☐ **1** No evidence of active TB	**1** Inform and advise - discharge	**A** Seen within 2 weeks of referral [if GP suspected pul.TB] **Yes** ☐ **No** ☐
☐ **2** Not TB Atypical - REFERRED	**2** Where referred? (detail in comments)	**B** All sputum smear results within 1 working day **Yes** ☐ **No** ☐
☐ **3** Active TB - TREAT	**3** Complete FORM 2: Initiate Rx [AUDIT E]	**C** Initial assessment completed **Yes** ☐ **No** ☐
☐ **4** Latent TB - TREAT	**4** Complete FORM 2: Initiate Rx	**D** Referred to Find & Treat if : **Yes** ☐ **No** ☐
☐ **5** Latent TB – Not treated/declined	**5** Inform, advise and arrange follow up	High risk (see *) or LFU pre-diagnosis of AFB+ TB contact
☐ **6** LFU prior to diagnostic decision	Detail plan in comments	**E** (Calculate in days for **Active TB cases only** – see definitions sheet)
☐ BCG to be given	6 Refer to Find & Treat: Action / Info [AUDIT D]	1) Patient delay _____ days
		2) Health Service delay _____ days
		3) Total delay _____ days

Initial assessment by (Name): _____ **Date:** _____

Signature: _____ **Designation:** _____

Source:
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