

## Pacific Island Jurisdiction TB Medical Consultation Request

Request Date:		<b>Primary Question for Consultant</b>									
Request Type: <input type="checkbox"/> Initial <input type="checkbox"/> Follow-up											
Requester Name:		Q1:									
Title:											
Phone: (    )											
Fax: (    )											
Email:		Q2:									
Email2:											
Country or jurisdiction		<b>Patient Summary:</b>									
<input type="checkbox"/> American Samoa <input type="checkbox"/> FSM Chuuk <input type="checkbox"/> RMI Ebeye <input type="checkbox"/> FSM Yap <input type="checkbox"/> RMI Majuro <input type="checkbox"/> Palau <input type="checkbox"/> FSM Kosrae <input type="checkbox"/> Guam <input type="checkbox"/> FSM Pohnpei <input type="checkbox"/> CNMI											
Type of Patient: <input type="checkbox"/> New <input type="checkbox"/> Relapse <input type="checkbox"/> Failure <input type="checkbox"/> Treatment after Interruption <input type="checkbox"/> Other											
History of TB in this patient, or family or friends? <input type="checkbox"/> Yes If yes: Who? When?            Where?					Pt DOB(mm/dd/yy)		Age	Sex: <input type="checkbox"/> F <input type="checkbox"/> M	Wgt ___ lbs ___ KG		
Previous treatment for TB disease: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown            Dates of previous TB treatment:											
Did patient complete previous treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown											
Hosp Admit date:			Discharge date:			Prior hospitalization date?:			Local Patient #:		
Symptoms/ (Duration)		<input type="checkbox"/> Persistent cough: _____		<input type="checkbox"/> HemoptysisL: _____		<input type="checkbox"/> Fatigue: _____		<input type="checkbox"/> Weight loss: _____			
		<input type="checkbox"/> Loss of appetite: _____		<input type="checkbox"/> Chills: _____		<input type="checkbox"/> Fever: _____		<input type="checkbox"/> Night sweats: _____			
<b>Bacteriology</b>					<b>Current treatment or drug availability</b>						
Specimen Type	Date collected	Local Smear result	MTB Culture result	Anti-microbial susceptibility	Drugs	Description or select phase (IP or CP)	Start Date	Stop Date	Reason		
<input type="checkbox"/> Sputum <input type="checkbox"/> Other			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend	<input type="checkbox"/> None <input type="checkbox"/> Mono _____ MDR	INH						
					RIF						
<input type="checkbox"/> Sputum <input type="checkbox"/> Other			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend	<input type="checkbox"/> None <input type="checkbox"/> Mono _____ MDR	PZA						
					EMB						
<input type="checkbox"/> Sputum <input type="checkbox"/> Other			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend	<input type="checkbox"/> None <input type="checkbox"/> Mono _____ MDR	SM						
					Other 1						
<input type="checkbox"/> Sputum <input type="checkbox"/> Other			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend	<input type="checkbox"/> None <input type="checkbox"/> Mono _____ MDR	Other 2						
					Other 3						
<input type="checkbox"/> Sputum <input type="checkbox"/> Other			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend	<input type="checkbox"/> None <input type="checkbox"/> Mono _____ MDR	Other 4						
<input type="checkbox"/> Sputum <input type="checkbox"/> Other			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend	<input type="checkbox"/> None <input type="checkbox"/> Mono _____ MDR							
<b>Radiology</b>					Current treatment type: <input type="checkbox"/> DOT <input type="checkbox"/> SAT <input type="checkbox"/> Both						
Date taken		Cavitary Y or N	Changes or other comments/impressions			Additional comments					

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**Background:** Through a cooperative agreement with CDC, the San Francisco (SF) Regional Training and Medical Consultation Center (RTMCC) also known as the Francis. J. Curry National TB Center will be providing expert medical consultation to the U.S. – affiliated Pacific Islands. This process is outlined below. The Francis. J. Curry National TB Center web address is: <http://www.nationaltbcenter.edu/>

### A. How do I request TB medical consultation:

1. Complete request form paying particular attention to filling out what is the particular question(s) that the requesting physician has about the case.
2. Submit your form using one of 2 options
  - A. Email: The **subject line** should include: **Medical consultation request**  
Email to [tbcenter@nationaltbcenter.edu](mailto:tbcenter@nationaltbcenter.edu)
  - B. Fax: (415) 502-4620
3. Clinicians from the RTMCC will respond to your request within 1 business day of their receipt and might contact you for additional clinical information. CDC will assist in establishing any necessary conference calls to facilitate the medical consultation

Please implement this same process for repeated consultation requests for the same patient. To initiate a medical inquiry Please do not email the consultants directly.

### B. How to I complete the form:

1. Request date: enter the date you are submitting this request to the RTMCC
2. Request type: select if this is an initial or a follow-up request
3. Requester name: provide the name of the requester, ideally the clinician in charge of the patient. provide this person's phone, fax, and email address
4. Jurisdiction: select the jurisdiction
5. Primary question for the consultant: provide the primary and secondary questions (TB-specific) along with a brief patient summary
6. Patient demographic and clinical information
  - a. select the type of patient according to WHO patient type classifications
  - b. provide patient's DOB or age at time of diagnosis, gender
  - c. provide past and current TB treatment information
  - d. identify patient's symptoms and duration of these symptoms
7. Provide bacteriology information; choose the type of specimen, date collected, local smear result, MTB culture result, and drug susceptibility results
8. Provide current treatment regimen, treatment phase, and start date
9. Provide radiology information including date CXR taken, evidence of cavitary disease, and interpretation
10. Provide additional clinical comments

C. What if I still have questions about the form, the process, or am unclear about the consultation service?

Email Andy Heetderks at [ajh1@cdc.gov](mailto:ajh1@cdc.gov)