

October 2024



West Virginia Department of Health Tuberculosis Elimination Program –
PHYSICIAN REQUESTING ADMISSION OF TUBERCULOSIS PATIENT TO STATE HOSPITAL

DATE: VOLUNTARY: COURT ORDERED:

PATIENT NAME: BIRTH DATE:

ADDRESS:

SEX: RACE: ETHNICITY: PLACE OF BIRTH:

OCCUPATION:

NORMAL WT: CURRENT WT: WT. LOSS PAST 6 MONTHS:

HIV STATUS KNOWN: RECEIVING HIV TREATMENT?

SIGNS AND SYMPTOMS OF TB – CIRCLE ALL THAT APPLY TO PATIENT

- COUGH SWEATS ANOREXIA
HEMOPTYSIS SEVERE FATIGUE HOARSENESS
FEVER NIGHT WEIGHT LOSS

CXR RESULTS: SPUTUM SMEAR/CULTURE RESULTS:

PREVIOUS TB TREATMENT? Yes No WHEN: WHERE:

DRUG USE / INJECTABLE DRUG USE WITHIN PAST YEAR: Yes No

EXCESS ALCOHOL USE WITHIN PAST YEAR: Yes No SMOKER: Yes No

HOMELESS WITHIN PAST YEAR: Yes No PREGNANT: Yes No

OTHER RISK FACTORS:

Health Officer Signature

County

I do I do not recommend the applicant for admission.

Sandra y. Elliott, MD - Medical Director WV-DTBE

DATE