**Sample Update Request Letter and Form for Patients Treated by Private or Community Providers**

Date: Re: DOB:

Dear *insert name*:

The *insert program name* requires a monthly status report on the above-named patient who is under your care and medical supervision for the treatment of tuberculosis.

Please complete and sign the attached Medical Update Form. All sections should be fully completed and returned within 7 days to *insert email address, fax number, and name of recipient*. If any smear, culture or sensitivity results have been received since the previous report please attach those as well.

According to HIPAA rule, PHI (protected health information) can be shared for public health, without individual authorization, to a public health authority. See [45 CFR 164.512(b)].

Your cooperation in this matter is appreciated. If you have any questions, please do not hesitate to contact this office at *insert number*.

Sincerely,

*Insert name and contact information*

**Sample Medical Update Form**

**Patient: DOB: Date of most recent physical exam: Weight:**

**Symptoms:**

* Cough: (if present, please specify if productive or non-productive):
*
* Fever
* Chest pain
* Weight loss ❑ Fatigue
* Decreased appetite ❑ Night sweats
* Hemoptysis ❑ Chills

**Medications, frequency, and dosages:**

**Bacteriology:**

**Results of most recent chest X-ray** (If abnormal, please indicate whether X-ray is stable, worsening, or improving):

**TST or IGRA results:**

|  |  |
| --- | --- |
| * TST
 | * IGRA
 |
| Date administered: Date read:  | Type of IGRA: Date:  |
| Millimeterreading:  | Result (including quantitative result):  |

**HIV status: Date TB treatment initiated: Expected length of TB treatment: Number of doses completed: If completed, date of completion:**

**Comments: Date of next appointment:**

**Signature of physician: Date:**