Appendix PM I

TIMS Forms

The Forms in this Appendix have been designed to duplicate the screen layouts in TIMS. It may be easier to complete the form when speaking with the client and input the information into TIMS after the visit is completed.

Client Module

Edit Client

CLIENT

(Last, First,, Middle) **CLIENT NAME:**		**DATE OF BIRTH:** / /	**Age:**
SS #:	**STATE CASE #:**	**CITY/COUNTY CASE #:**	
SITE:	**SPECIAL ATTENTION REQUIRED:** Explain		

Sex: (Check one) • Male • Female • Unknown

Race: (Check one)
- White
- Black
- American Indian or Alaskan Native
- Unknown
- Asian or Pacific Islander

Ethnic Origin: (Check one)
- Hispanic
- Non-Hispanic
- Unknown

Country of Origin: (Check one)
- US
- Not US
  Date Entered: ___/____ Country: _____
- Unknown

Language:
Primary Language: _____
Understand English: (Check one) • Yes • No
Speak English: (Check one) • Yes • No

Address:
Street: _____

_____

City: _____ State: _____

Within City Limits: (Check one) • Yes • No • Unknown

County: _____ Zip: _____

• Reporting Address • Current Address

Census Tract: _____

Address:
Street: _____

_____

City: _____ State: _____

Within City Limits: (Check one) • Yes • No • Unknown

County: _____ Zip: _____

• Reporting Address • Current Address

Census Tract: _____

Alert:

Reason: _____

Alias:
Name: (Last, First, Middle) _____
Date of Birth: _____

Name: (Last, First, Middle) _____
Date of Birth: _____

Phone:
Number: (___)_____ Description: _____
Number: (___)_____ Description: _____
Number: (___)_____ Description: _____
Number: (___)_____ Description: _____

User Defined Variable Information: (if needed)

General Comments: (Not to be entered into TIMS)

_____ ____/_____/____
Completed By Date

Patient Management Module

Appointments

APPOINTMENT

CLIENT NAME: (Last, First,, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Appointment Type: (check one)

- ☐ Bacteriology
- ☐ Blood Test
- ☐ Chest X-Ray
- ☐ HIV Test
- ☐ Physical Exam
- ☐ Skin Test
- ☐ Other Specify: _____

Location: _____

Worker Assigned: _____

Date: _____/_____/_____

Time: _____ ☐ a.m. ☐ p.m.

Repeat Cycle: (check one)

☐ **Daily/Weekly**

On what day(s):

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Every _____ **weeks**

Repeat _____ **times**

☐ **Monthly** **(specific day of month)**

Which week:

☐ 1st ☐ 2nd ☐ 3rd ☐ 4th

Day of week:

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Every _____ **months**

Repeat _____ **times**

☐ **Monthly** **(specific date)**

Date: _____

Every _____ **months**

Repeat _____ **times**

General Comments: *(Not to be entered into TIMS)*

_____ ____/_____/____

Completed By Date

Patient Management Module

Bacteriology Test

BACTERIOLOGY

CLIENT NAME: (Last, First,, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Date Collected: ___/____/____ **Laboratory**: _____

Specimen Type: __Sputum __Urine __Bronchial Washing __Biopsy __ Other

If Biopsy or Other, **Anatomic Site of Specimen**: (Enter a code from the 99 listings in TIMS) _____

Specimen ID #: _____

Smear Results: (Check one) __Negative __Positive __Not Done __Unknown __Other (Specify) _____

Culture Growth: (Check one) __Negative __Positive __Not Done __Unknown __Other (Specify) _____

Species ID: _____ **Date Identified**: ____/____/____

Date Collected: ___/____/____ **Laboratory**: _____

Specimen Type: __Sputum __Urine __Bronchial Washing __Biopsy __Other

If Biopsy or Other, **Anatomic Site of Specimen**: (Enter a code from the 99 listings in TIMS) _____

Specimen ID #: _____

Smear Results: (Check one) _Negative __Positive __Not Done __Unknown __Other (Specify) _____

Culture Growth: (Check one) _Negative __Positive __Not Done __Unknown __Other (Specify) _____

Species ID: _____ **Date Identified**: ____/____/____

User Defined Variable Information: (If needed)

_____ ____/_____/____

Completed By Date

Patient Management Module

SUSCEPTIBILITY

CLIENT NAME: (Last, First, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Test # ____ of _____ Date Reported: _____/____/____ Specimen ID #: _____ Lab: _____

Drug	Concentration (µg/mL)	Lab Findings	Method (check one in each column)	Susceptibility (check one)
_____	_____	_____	__Conventional __ Radiometric __ Direct ___ Indirect	__Resistant __ Susceptible __ Not Done __ Unknown
_____	_____	_____	__Conventional __ Radiometric __ Direct ___ Indirect	__Resistant __ Susceptible __ Not Done __ Unknown
_____	_____	_____	__Conventional __ Radiometric __ Direct ___ Indirect	__Resistant __ Susceptible __ Not Done __ Unknown
_____	_____	_____	__Conventional __ Radiometric __ Direct ___ Indirect	__Resistant __ Susceptible __ Not Done __ Unknown
_____	_____	_____	__Conventional __ Radiometric __ Direct ___ Indirect	__Resistant __ Susceptible __ Not Done __ Unknown
_____	_____	_____	__Conventional __ Radiometric __ Direct ___ Indirect	__Resistant __ Susceptible __ Not Done __ Unknown
_____	_____	_____	__Conventional __ Radiometric __ Direct ___ Indirect	__Resistant __ Susceptible __ Not Done __ Unknown
_____	_____	_____	__Conventional __ Radiometric __ Direct ___ Indirect	__Resistant __ Susceptible __ Not Done __ Unknown
_____	_____	_____	__Conventional __ Radiometric __ Direct ___ Indirect	__Resistant __ Susceptible __ Not Done __ Unknown
_____	_____	_____	__Conventional __ Radiometric __ Direct ___ Indirect	__Resistant __ Susceptible __ Not Done __ Unknown
_____	_____	_____	__Conventional __ Radiometric __ Direct ___ Indirect	__Resistant __ Susceptible __ Not Done __ Unknown
_____	_____	_____	__Conventional __ Radiometric __ Direct ___ Indirect	__Resistant __ Susceptible __ Not Done __ Unknown
_____	_____	_____	__Conventional __ Radiometric __ Direct ___ Indirect	__Resistant __ Susceptible __ Not Done __ Unknown

User Defined Variable Information: (If needed)

_____ ____/_____/____

Completed By Date

Patient Management Module

BLOOD TEST

CLIENT NAME: (Last, First,, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Date: ___/____/____ **Uric Acid**: _____

SGOT (AST): _____ **Creatinine**: _____

Bilirubin: _____ **CBC with Platelets**: _____

User Defined Variable Information: (If needed)

General Comments: (Not to be entered into TIMS)

_____ ____/_____/____
Completed By Date

Patient Management Module

HIV TEST

CLIENT NAME: (Last, First, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Was HIV Test Offered?: (Check one) __Yes __No __Unknown **If Yes, Date Offered**:___/___/___

Was HIV Test Administered?: (Check one) __Yes __No __Unknown **If Yes, Date of Test**: ___/___/___

HIV Status: (Check one)

__ Positive
__ Negative
__ Done, Results Unknown
__ Undefined
__ Unknown

If Not Tested, Reason: (Check one)

__Previously Positive **Previous Positive Test Date:** ___/___/___
__Previously Negative **Previous Negative Test Date:** ___/___/___
__Referred Elsewhere
__Client Denied
__Other (specify reason) _____

If Positive, Based on:

__Medical Documentation
__Patient History
__Unknown

CDC AIDS Patient #: _____
State HIV/AIDS Patient #: _____
City HIV/AIDS Patient #: _____

Client Post Counseling: (Check one)

__Yes **If Yes, Date of Post Test Counseling**: ____/____/____
__No

User Defined Variable Information: (If needed)

General Comments: (Not to be entered into TIMS)

_____ ____/_____/____
Completed By Date

Patient Management Module

PHYSICAL EXAM

CLIENT NAME: (Last, First, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Test Type:

Hearing Date of Test: ____/____/____ Results _____db

Vision-Acuity Date of Test: ____/____/____ Results _____

Vision-Color Date of Test: ____/____/____ Results _____

Weight Date of Test: ____/____/____ Results _____ (Check one) __lbs __ kgs

INH Metabolite Date of Test: ____/____/____ Results _____

User Defined Variable Information: (If needed)

General Comments: (Not to be entered into TIMS)

_____ ____/_____/____

Completed By Date

Patient Management Module

SKIN TEST

CLIENT NAME: (Last, First, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Type of Test: (Check one)
☐ Tuberculin ☐ Tetanus ☐ Candida ☐ Mumps

Date Tested: ____/____/____ **By**: (name) _____

Date Read: ____/____/____ **By**: (name) _____

Induration (mm) : _____ **Results**: (Check one) ☐ Positive ☐ Negative ☐ Unknown

Comments: *(CAN be entered into TIMS)* _____

Does the Patient meet the CDC Criteria for being classified as a Converter: (Check one)
☐ Yes ☐ No ☐ Unknown

Type of Test: (Check one)
☐ Tuberculin ☐ Tetanus ☐ Candida ☐ Mumps

Date Tested: ____/____/____ **By**: (name) _____

Date Read: ____/____/____ **By**: (name) _____

Induration (mm): _____ **Results**: (Check one) ☐ Positive ☐ Negative ☐ Unknown

Comments: *(CAN be entered into TIMS)* _____

Does the Patient meet the CDC Criteria for being classified as a Converter: (Check one)
☐ Yes ☐ No ☐ Unknown

User Defined Variable Information: (If needed)

_____ ____/____/____
Completed By Date

Patient Management Module

CHEST X-RAY

CLIENT NAME: (Last, First, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

View: (Check one)

- ☐ Posterior/Anterior
- ☐ Lateral
- ☐ Other_____

Date Taken: _____/____/____

By: _____ or **Where**: _____

Date Read: ____/____/_____

Read By: _____

Results: (Check one)

- ☐ Normal ☐ Not Done
- ☐ Abnormal ☐ Unknown

If abnormal, Abnormality: (Check one)

- ☐ Cavitary
- ☐ Noncavitary consistent with TB
- ☐ Noncavitary *not* consistent with TB
- ☐ Unknown

Status: (Check one)

- ☐ Stable
- ☐ Worsening
- ☐ Improving
- ☐ Unknown

User Defined Variable Information: (If needed)

General Comments: *(Can be entered into TIMS)*

_____ ____/_____/____

Completed By Date

Patient Management Module

CONTACTS

CLIENT NAME: (Last, First, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Interview Information

Date:	Interviewer:
____/____/____	_____
____/____/____	_____
____/____/____	_____
____/____/____	_____

Exposure Sites

Site	Address	City	State	Phone
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Date Identified: _____/____/_____ **Interview Date**: _____/____/_____

Last Name: _____

First Name: _____

Address: _____

_____

City: _____ **State**: _____

County: _____ **Zip**: _____-_____

Exposure Site: _____

Priority: ☐Close ☐ Casual **Last Exposure Date**: ___/___/_____

Indicated for Exam: (Check one) ☐ Yes ☐ No

Relationship: _____

Birthdate: _____/___/_____

Age: _____

Phone: (____)_____

User Defined Variable Information: (If needed)

_____ ____/_____/____

Completed By Date

CONTACTS

CLIENT NAME: (Last, First,, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Date Identified: _____/____/_____ **Interview Date**: _____/____/_____

Last Name: _____

First Name: _____

Address: _____

_____

City: _____ **State**: _____

County: _____ **Zip**: _____-_____

Exposure Site: _____

Priority: ☐ Close ☐ Casual **Last Exposure Date**: ___/___/____

Indicated for Exam: (Check one) ☐ Yes ☐No

Relationship: _____

Birthdate: _____/___/_____

Age: _____

Phone: (____)_____

Date Identified: _____/____/_____ **Interview Date**: _____/____/_____

Last Name: _____

First Name: _____

Address: _____

_____

City: _____ **State**: _____

County: _____ **Zip**: _____-_____

Exposure Site: _____

Priority: ☐ Close ☐ Casual **Last Exposure Date**: ___/___/_____

Indicated for Exam: (Check one) ☐ Yes ☐ No

Relationship: _____

Birthdate: _____/___/_____

Age: _____

Phone: (____)_____

_____ ____/_____/____

Completed By Date

Patient Management Module

DIAGNOSIS

CLIENT NAME: (Last, First, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Date: ____/____/____ **Diagnostician:** _____

Check if client is being screened: ☐ If yes, Format: ☐ Admin ☐ Individual ☐ Project ☐ Referral

If yes, Activity/Group: _____

Check if client has been in contact with active TB ☐

Diagnosis:

☐ Not Infected ☐ Suspect ☐ Not TB
☐ Infected ☐ Old TB
☐ Case ☐ Rule Out Infection

If Diagnosis is Infected or Rule Out Infection, is client a Candidate for Treatment? ☐ Yes ☐ No

ATS classification number: _____

If Diagnosis is Case or Suspect, Major Site of Disease: _____

If the Diagnosis is Case or Suspect, is disease:

☐ Pulmonary ☐ Extrapulmonary ☐ Both

Has client had curative therapy in the past?: (Check one) ☐ Yes ☐ No ☐ Unknown

User Defined Variable Information: (If needed)

General Comments: (Not to be entered into TIMS)

_____ ____/_____/____
Completed By Date

Patient Management Module

HISTORY

CLIENT NAME: (Last, First, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Present Illness: (Include present signs and symptoms)_____

Risk Factors for TB Infection/Disease: ☐ Medical ☐ Population ☐ Medical and Population ☐ None

Medical History

Previous Diagnosis of TB: (Check one)
☐ Yes ☐ No ☐ Unknown
If Yes, Month/Year of Diagnosis: _____/_____
More than one previous episode: ☐ Yes ☐ Unknown

Previous Skin Test for TB: (Check one)
☐ Yes ☐ No ☐ Unknown
If Yes, _____ mm
If Yes, Results: ☐ + ☐ - ☐ Unknown
If Yes, Month/Yea r: _____/_____

BCG Vaccination: (Check one)
☐ Yes ☐ No ☐ Unknown
If Yes, Date: _____/_____/_____

Prior HIV Test: (Check one)
☐ Yes ☐ No ☐ Unknown
If Yes, Results: ☐ + ☐ - ☐ Unknown
If Yes, Month/Year: _____/_____

Diabetes: (Check one)
☐ Yes ☐ No ☐ Unknown
If Yes, Insulin? ☐ Yes ☐ No

Hospitalized in Last Year: (Check one)
☐ Yes ☐ No ☐ Unknown
If Yes, Where/Why: (Limit 40 characters)

Current Tobacco Use: (Check one)
☐ Yes ☐ No ☐ Unknown
If Yes, Amount: (Check one below)
☐ Pk/Day ☐ Pk/Wk
☐ Pk/Mo ☐ Cig/Day ☐ Cig/Wk ☐ Cig/Mo

Silicosis: (Check one)
☐ Yes ☐ No ☐ Unknown

Leukemia/Lymphoma/Other Malignancies: (Check one)
☐ Yes ☐ No ☐ Unknown

Gastrectomy/Internal Bypass:
☐ Yes ☐ No ☐ Unknown

Hepatitis: (Check one)
☐ Yes ☐ No ☐ Unknown

Immunosuppressive Therapy:
☐ Yes ☐ No ☐ Unknown

Pregnant: (Check one)
☐ Yes ☐ No ☐ Unknown

Kidney Failure: (Check one)
☐ Yes ☐ No ☐ Unknown

Is Client Taking any Medications that could interact with TB Medications? (Check one)
☐ Yes ☐ No
If Yes, Specify: _____

Medication Allergies:

Homeless within Past Year: (Check one)
☐ Yes ☐ No ☐ Unknown

HISTORY

CLIENT NAME: (Last, First, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Resident of Correctional Facility at Time of Diagnosis?
☐ Yes ☐ No ☐ Unknown.

If Yes, (Check one)
☐ Federal Prison ☐ State Prison
☐ Juvenile Correctional Facility
☐ Local Jail
☐ Other Correctional Facility ☐ Unknown

Resident of Long-Term Care Facility at Time of Diagnosis?
☐ Yes ☐ No ☐ Unknown

If Yes, (Check one)
☐ Nursing Home
☐ Hospital-Based Facility
☐ Residential Facility
☐ Mental Health Residential
☐ Other Long-Term Care Facility
☐ Alcohol/Drug Treatment Facility
☐ Unknown

Within the past 12 months, does client have a history of: (Check one)

Injected Drug Use	☐ Yes ☐ No ☐ Unknown
Non-Injected Drug Use	☐ Yes ☐ No ☐ Unknown
Excess Alcohol	☐ Yes ☐ No ☐ Unknown

Occupation: (Check all that apply within the past 24 months)

☐ Health Care Worker ☐ Migratory Agricultural Worker
☐ Correctional Employee ☐ Other: Specify _____
☐ Unknown ☐ Not Employed in Past 24 Months

User Defined Variable Information: (If needed)

_____ ____/_____/____
Completed By Date

Patient Management Module

HOSPITALIZATION

CLIENT NAME: (Last, First,, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Chart Number: _____

Admission Date: _____/_____/_____

Discharge Date: _____/_____/_____

Facility Name: _____

Facility Type: _____

Phone: (_____)_____-_____

TB Medication was provided: (check one) __Yes __No

User Defined Variable Information: (If needed)

General Comments: (Can be entered into TIMS)

_____ ____/_____/____
Completed By Date

Patient Management Module

REFERRAL

CLIENT NAME: (Last, First, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Referral Date: ___/___/___ **Referral Reason:** _____

Referral Source: _____

Name: _____

Address: _____

_____

City: _____ **State** _____ **Zip** _____

Phone: (_____)_____-_____

User Defined Variable Information: (If needed)

General Comments: (Not to be entered into TIMS)

_____ ____/_____/____

Completed By Date

Patient Management Module

MEDICATIONS

CLIENT NAME: (Last, First, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Drug: _____ **Dosage**: ____.___ mg cc ml g dl **Route**: __Oral __ Intramuscular __ Intravenous **Duration**: _____(wks)

Frequency: __Daily _____ times Weekly **Start Date**: _____/_____/_____ **Prescribed By**: _____ **Location**: _____

Worker Assigned: _____ **Repeat Cycle**: __Daily __ Weekly __ Monthly **On what day(s): S M T W TH F S** **Every ____ weeks / Repeat ____ times**

Drug: _____ **Dosage**: ____.___ mg cc ml g dl **Route**: __Oral __ Intramuscular __ Intravenous **Duration**: _____(wks)

Frequency: __Daily _____ times Weekly **Start Date**: _____/_____/_____ **Prescribed By**: _____ **Location**: _____

Worker Assigned: _____ **Repeat Cycle**: __Daily __Weekly __ Monthly **On what day(s): S M T W TH F S** **Every ____ weeks / Repeat ____ times**

Drug: _____ **Dosage**: ____.___ mg cc ml g dl **Route**: __Oral __ Intramuscular __Intravenous **Duration**: _____(wks)

Frequency: __ Daily _____ times Weekly **Start Date**: _____/_____/_____ **Prescribed By**: _____ **Location**: _____

Worker Assigned: _____ **Repeat Cycle**: __Daily __Weekly __ Monthly **On what day(s): S M T W TH F S** **Every ____ weeks / Repeat ____ times**

General Comments: (Not to be entered into TIMS)

_____ ____/_____/____

Completed By Date

Patient Management Module

DRUG PICKUPS

CLIENT NAME: (Last, First,, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Directly Observed Therapy **Month** _____ **Year** _____

Initial and enter code for each day ***D*** *= Delivered* ***M*** *= Missed* ***H*** *= Hospital* ***S*** *= Self Administered*

Drug							
Dosage							**Comments**
Day							
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							

Self-Administered

Drug							
Date Dispensed							
# Doses Dispensed							
# Doses Leftover							

Signature	Initials	Signature	Initials	Signature	Initials

-END OF TIMS FORMS-