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

CLIENT NAME: (Last, First,, Middle)		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) __________

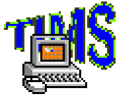
Species ID: ____ **Date Identified**: ____/____/____

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

TIMS

(Last, First, Middle) CLIENT NAME:		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

<table>
<tr><td colspan="2">(Last, First, Middle)
CLIENT NAME:</td><td>DATE OF BIRTH: / /</td><td>Age:</td></tr>
<tr><td>SS #:</td><td>STATE CASE #:</td><td colspan="2">CITY/COUNTY CASE #:</td></tr>
<tr><td>SITE:</td><td colspan="3">Explain
SPECIAL ATTENTION REQUIRED:</td></tr>
</table>

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 ________________

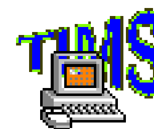
User Defined Variable Information: (If needed)

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)* ______________________________

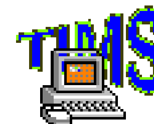
Does the Patient meet the CDC Criteria for being classified as a Converter: (Check one)
☐ Yes ☐ No ☐ Unknown

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 Page 1 of 2

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

Patient Management Module

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

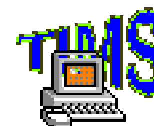
Is Client Taking any Medications that could interact with TB Medications? (Check one)
☐ Yes ☐ No

If Yes, Specify: ____

Medication Allergies:

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

Patient Management Module



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

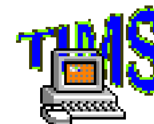
User Defined Variable Information: (If needed)

General Comments: (Can be entered into TIMS)

______________________ ____/_____/____
Completed By Date

Patient Management Module

REFERRAL



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

Referral Date: ___/___/___ **Referral Reason:** ____

Referral Source: _____________________________________

Name: ____

Address: ____

____

City: ____________________________ **State** ______ **Zip** ________________

Phone: (_____)______-____________

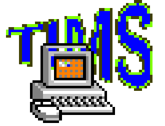
User Defined Variable Information: (If needed)

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-