TENNESSEE DEPARTMENT OF HEALTH
TUBERCULOSIS ELIMINATION PROGRAM
425 5th AVENUE NORTH
CORDELL HULL BUILDING, FIRST FLOOR
NASHVILLE, TENNESSEE 37243
Ph: (615)741-7247 Fax: (615)253-1370

Fluoroquinolone Exposure Assessment

Instructions: Complete this form for *each* tuberculosis (TB) suspect or case, regardless of age, at the initiation of anti-TB treatment. Fax a copy to the Central Office, and file the original form in the patient's medical record.

Patient Name: _____ **Date of birth:** ____/____/____

PTBMIS #: _____ **Age:** _____ yrs

A. HOSPITALIZATIONS

Has the patient been hospitalized in the 6 months before starting TB treatment? ☐ Yes ☐ No ☐ Don't know

B. TUBERCULOSIS (TB) INFORMATION

Start date of anti-TB medications: ____/____/____

Did the patient receive *any antibiotics* in the 6 months before starting TB treatment? ☐ Yes [continue below] ☐ No [stop here] ☐ Don't know [stop here]

C. FLUOROQUINOLONE EXPOSURES

Please provide the following information for *each time* the patient received any of the following antibiotics in the 6 months prior to starting TB treatment.

Name of Antibiotic _____ Generic name / (Trade name)	**Received in the past 6 months?** _____ (Circle **Y**es, **N**o, or **D**on't **K**now)	**Start date of antibiotic** _____ (MM / DD / YY)	**# of days patient took this medicine** _____ (Indicate number; if unknown, circle **DK**)	**Reason for taking antibiotic*** _____ (Circle number corresponding to the reason listed below)
Ciprofloxacin / (Cipro)	Y N DK	/ /	_____ days DK	1 2 3 4 5 6
Gatifloxacin / (Tequin)	Y N DK	/ /	_____ days DK	1 2 3 4 5 6
Levofloxacin / (Levaquin)	Y N DK	/ /	_____ days DK	1 2 3 4 5 6
Moxifloxacin / (Avelox)	Y N DK	/ /	_____ days DK	1 2 3 4 5 6
Ofloxacin / (Floxin)	Y N DK	/ /	_____ days DK	1 2 3 4 5 6

***Code** (reason for antibiotic): **1**=bronchitis, **2**=pneumonia, **3**=sinusitis, **4**=urinary tract infection, **5**=diarrhea, **6**=other

Completed by: _____, MD / RN **Date:** ____/____/____

Public Health Region: _____