Kentucky Pharmacy Disease Reporting Form

Department for Public Health
Division of Epidemiology and Health Planning
275 East Main St., Mailstop HS2E-B2
Frankfort, KY 40621-0001

EPID TB-1 (Pharmacist Reporting)

Disease Name__Tuberculosis____

Fax the Completed Form to the Local Health Department (TB Coordinator) of patient's residency within one (1) business day

DEMOGRAPHIC DATA				
Patient's Last Name First M.I.	Date of Birth / /	Age	Gender ☐ M ☐F ☐ Unk	
Address City State Zip			County of Residence	
Phone Number	Patient ID Number	Ethnic Origin ☐ His. ☐ Non-His.	Race ☐W ☐B ☐A/PI ☐Am.Ind. ☐Other	

PHARMACY INFORMATION	
Person or Agency Completing form: Name: Agency:	Attending Physician: Name:
Address:	Address:
Phone: Date of Report: / /	Phone:

MEDICATION INFORMATION				
Date	Name of Medication	Strength of Medication	Quantity	Notes
	Rifampin (RIF)			
	Isoniazid (INH)			
	Pyrazinamide (PZA)			
	Ethambutol (EMB)			
	Other (List)			
	Other (List)			

COMMENTS:

Revised 07/2024