



**Kentucky Reportable Disease Form**  
**Department for Public Health**  
**Division of Epidemiology and Health Planning**  
**275 East Main St., Mailstop HS2E-A**  
**Frankfort, KY 40621-0001**

**EPID TB-1 (Pharmacist Reporting)**

Disease Name Tuberculosis

**Fax the Completed Form to the Local Health Department (TB Coordinator) within one (1) business day**

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

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

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

COMMENTS: