



**TEXAS DEPARTMENT OF STATE HEALTH SERVICES
HANSEN'S DISEASE ENCOUNTER FORM**

Texas Department of State Health Services

Encounter Date:

Patient Name:			Clinic:		
DOB:	SSN:	Gender:	MD:		
Address:			Contact:		
Phone:					
Insurance:		HD Type:	Year Dx:		Type of Visit:
Other Insurance:		Last Skin Smear:			Service Provided: Rx (medication) refill Screens
		Results:			Labs Education Callous trim Wound care
Allergies:		Last Biopsy:			Other:
		Results:			Status:

Multi-Drug Therapy:									
Drug	Dosage	Frequency	Start Date	Stop Date	Reason Discontinued	Re-Start Date	Re-Stop Date	Refill Needed Yes/No	Refill Duration
Dapsone									
Rifampin									
Clofazamine									
Clarithromycin									
Minocycline									
Levofloxacin									

Reaction Medications:									
Clofazamine									
Methotrexate									
Prednisone									
Thalidomide									

Other Prescribed Medications:									

Client Education: Compliance to Chemotherapy Cause/Transmission Drug Regimen/Toxicity Reaction(s) Care of Hands/Feet/Eyes Acceptance	Screens (Baseline, Quarterly, as needed): Hands Feet Eyes Medical Compliance/Tolerance: Annual Follow-up Form Date last completed:	Reactional State: Type I - Reversal Type II - Erythema Nodosum Leprosum (ENL) Both Lucio Uncertain	Consult/Referral date: Type of consult: Other referral: Name of referral site: Reason for referral:
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Ht:	Wt:	Temp:	BP:	Pulse:
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Laboratory Tests:				
<i>Initial visit:</i>		<i>Follow-up visits:</i>	<i>Other labs as needed:</i>	<i>Other tests as needed:</i>
CBC + platelets	G6PD	CBC + platelets	CMP	UA
CMP (includes AST/ALT/BUN/Creatine/Bilirubin)	Hepatitis B*	CRP	BMP	Occult Blood
CRP	Hepatitis C*	AST	Bilirubin	Ova Parasites
Other, specify:	<small>Screen if patient has risk factors and may need prednisone</small>	ALT	Alkaline Phos	PCR
		Other, specify:	Eosinophil count	Other, specify:
			Other, specify:	

PHN Signature:	Date:
Physician Signature:	Date:

Patient Name:

DOB:

Progress notes:

Date of note: