

REPORT OF VERIFIED CASE OF TUBERCULOSIS

17. Sputum Smear (select one) Date Collected: _____
 Positive Not Done
 Negative Unknown

18. Sputum Culture (select one) Date Collected: _____ Date Result Reported: _____
 Positive Not Done
 Negative Unknown
 Reporting Laboratory Type (select one): Public Health Laboratory Commercial Laboratory Other

19. Smear/Pathology/Cytology of Tissue and Other Body Fluids (select one) Date Collected: _____ Enter anatomic code (see list): _____ Type of exam (select all that apply): Smear Pathology/Cytology
 Positive Not Done
 Negative Unknown

20. Culture of Tissue and Other Body Fluids (select one) Date Collected: _____ Enter anatomic code (see list): _____ Date Result Reported: _____
 Positive Not Done
 Negative Unknown
 Reporting Laboratory Type (select one): Public Health Laboratory Commercial Laboratory Other

21. Nucleic Acid Amplification Test Result (select one) Date Collected: _____ Date Result Reported: _____
 Positive Not Done
 Negative Unknown
 Indeterminate
 Enter specimen type: Sputum OR If not Sputum, enter anatomic code (see list): _____
 Reporting Laboratory Type (select one): Public Health Laboratory Commercial Laboratory Other

Initial Chest Radiograph and Other Chest Imaging Study

22A. Initial Chest Radiograph (select one) Normal Abnormal* (consistent with TB) Not Done Unknown
 * For ABNORMAL Initial Chest Radiograph: Evidence of a cavity (select one): Yes No Unknown
 Evidence of miliary TB (select one): Yes No Unknown

22B. Initial Chest CT Scan or Other Chest Imaging Study (select one) Normal Abnormal* (consistent with TB) Not Done Unknown
 * For ABNORMAL Initial Chest Radiograph: Evidence of a cavity (select one): Yes No Unknown
 Evidence of miliary TB (select one): Yes No Unknown

23. Tuberculin (Mantoux) Skin Test at Diagnosis (select one) Date Tuberculin Skin Test (TST) Placed: _____ Millimeters (mm) of induration: _____
 Positive Not Done
 Negative Unknown

24. Interferon Gamma Release Assay for Mycobacterium tuberculosis at Diagnosis (select one) Date Collected: _____
 Positive Not Done
 Negative Unknown
 Indeterminate
 Test type: Specify _____

25. Primary Reason Evaluated for TB Disease (select one)

- TB Symptoms
- Abnormal Chest Radiograph (consistent with TB)
- Contact Investigation
- Targeted Testing
- Health Care Worker
- Employment/Administrative Testing
- Immigration Medical Exam
- Incidental Lab Result
- Unknown

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26. HIV Status at Time of Diagnosis (select one)

- Negative Indeterminate Not Offered Unknown
 Positive Refused Test Done, Results Unknown

If POSITIVE, enter:

State HIV/AIDS Patient Number:

City/County HIV/AIDS Patient Number:

27. Homeless Within Past Year (select one)

- No Yes Unknown

28. Resident of Correctional Facility at Time of Diagnosis (select one)

- No Yes Unknown

If YES, (select one):

- Federal Prison Local Jail Other Correctional Facility
 State Prison Juvenile Correction Facility Unknown

If YES, under custody of Immigration and Customs Enforcement? (select one)

- No Yes

29. Resident of Long-Term Care Facility at Time of Diagnosis (select one)

- No Yes Unknown

If YES, (select one):

- Nursing Home Residential Facility Alcohol or Drug Treatment Facility Unknown
 Hospital-Based Facility Mental Health Residential Facility Other Long-Term Care Facility

30. Primary Occupation Within the Past Year (select one)

- Health Care Worker Migrant/Seasonal Worker Retired Not Seeking Employment (e.g. student, homemaker, disabled person)
 Correctional Facility Employee Other Occupation Unemployed Unknown

31. Injecting Drug Use Within Past Year (select one)

- No Yes Unknown

32. Non-Injecting Drug Use Within Past Year (select one)

- No Yes Unknown

33. Excess Alcohol Use Within Past Year (select one)

- No Yes Unknown

34. Additional TB Risk Factors (select all that apply)

- Contact of MDR-TB Patient (2 years or less) Incomplete LTBI Therapy Diabetes Mellitus Other Specify _____
 Contact of Infectious TB Patient (2 years or less) TNF- α Antagonist Therapy End-Stage Renal Disease None
 Missed Contact (2 years or less) Post-organ Transplantation Immunosuppression (not HIV/AIDS)

35. Immigration Status at First Entry to the U.S. (select one)

- Not Applicable Immigrant Visa Tourist Visa Asylee or Parolee
 "U.S.-born" (or born abroad to a parent who was a U.S. citizen) Student Visa Family/Fiancé Visa Other Immigration Status
 Born in 1 of the U.S. Territories, U.S. Island Areas, or U.S. Outlying Areas Employment Visa Refugee Unknown

36. Date Therapy Started

Month: Day: Year:

37. Initial Drug Regimen (select one option for each drug)

	No	Yes	Unk		No	Yes	Unk		No	Yes	Unk
Isoniazid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ethionamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Moxifloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifampin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amikacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cycloserine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pyrazinamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kanamycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Para-Amino Salicylic Acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethambutol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Capreomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Streptomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____			
Rifabutin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Levofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifapentine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____			

Comments:

Patient's Name _____ (Last) _____ (First) _____ (M.I.) State Case No. _____

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)
ATLANTA, GEORGIA 30333
FORM APPROVED OMB NO. 0920-0026 Exp. Date 05/31/2011

Case Completion Report - Continued

(Follow Up Report - 2)

47. Directly Observed Therapy (DOT) (select one)

- No, Totally Self-Administered
- Yes, Totally Directly Observed
- Yes, Both Directly Observed and Self-Administered
- Unknown

Number of weeks of directly observed therapy (DOT)

48. Final Drug Susceptibility Testing

Was follow-up drug susceptibility testing done? (select one) No Yes Unknown

If NO or UNKNOWN, do not complete the rest of Follow Up Report -2

If YES, enter date FINAL isolate collected for which drug susceptibility testing was done:

Enter specimen type: Sputum

OR

If not Sputum, enter anatomic code (see list):

Month Day Year

49. Final Drug Susceptibility Results (select one option for each drug)

	Resistant	Susceptible	Not Done	Unknown		Resistant	Susceptible	Not Done	Unknown
Isoniazid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Capreomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifampin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pyrazinamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Levofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethambutol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Streptomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Moxifloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifabutin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Quinolones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifapentine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cycloserine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethionamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Para-Amino Salicylic Acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amikacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kanamycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____				
					Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Specify _____				

Comments:

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