Patient's Name _			
	(Last)	(First)	(M.I.



REPORT OF VERIFIED CASE OF TUBERCULOSIS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES-FORM APPROVED OMB NO. 0920-0026 Exp. Date 05/31/2011

1. Date Reported	3. Case Numbers Year Reporte	ed (YYYY) State	Code Locally Assigned	Identification Number
Month Day Year	State Case Number City/County			
2. Date Submitted	Case Number			Reason:
Month Day Year	Linking State Case Number Linking State Case Number			
4. Reporting Address for Case Counting			8. Date of Birth	
City Within City Limits (select one)	Yes No		Month Day	Year
County			9. Sex at Birth (select one) Male Female	11. Race (select one or more) American Indian or Alaska Native Asian: Specify
5. Count Status (select one) Countable TB Case Count as a TB case	6. Date Counted Month Day	Year	10. Ethnicity (select one) Hispanic or Latino Not Hispanic or Latino	Asian: Specify Black or African American Native Hawaiian or Other Pacific Islander: Specify White
Noncountable TB Case Verified Case: Counted by another U.S. area (e.g., county, state)	7. Previous Diagnosis of TB Disea	ase (select one)	12. Country of Birth "U.Sborn" (or born abro (select one) Yes Country of birth: Specify	oad to a parent who was a U.S. citizen)
Verified Case: TB treatment initiated in another country Specify Verified Case: Recurrent TB within 12 months after completion of therapy	If YES, enter year of previous TB o	disease diagnosis:	13. Month-Year Arrived in Month	U.S. Year
14. Pediatric TB Patients (<15 years old) Country of Birth for Primary Guardian(s): Specific Guardian 1 Guardian 2 Patient lived outside U.S. for >2 months? (select one) If YES, list countries, specify: 15. Status at TB Diagnosis (select one) Alive Dead Month If DEAD, enter date of death:	•	Pulmon Pleural Lympha Lympha Lympha Lympha Lympha	Genitou atic: Cervical Mening atic: Intrathoracic Peritone atic: Axillary Other: E atic: Other Site not atic: Unknown	eal Enter anatomic code(s) (see list):
If DEAD, was TB a cause of death? (select on	· —	L Larynge	5CU	

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17. Sputum Smear (select one)	Date Collected:	`
Positive Not Done	Month Day Year	
☐ Negative ☐ Unknown		
La Negative La Unknown		
18. Sputum Culture (select one)	Date Collected: Date	Result Reported:
		lonth Day Year
☐ Negative ☐ Unknown		
	Reporting Laboratory Type (select one): Public Health	☐ Commercial ☐ au
	Laboratory	Commercial Other
19. Smoot/Pathology/Cutology	of Tissue and Other Body Fluids (select one)	
		er anatomic code Type of exam (select all that apply):
Positive Not Done		liet):
☐ Negative ☐ Unknown	INIOTILIT Day Teal	Smear Pathology/Cytology
20. Culture of Tissue and Other	Body Fluids (select one) Ente	r
☐ Positive ☐ Not Done	Date Collected.	omic code Date Result Reported:
☐ Negative ☐ Unknown	Month Day Year	list): Month Day Year
Negative Unknown		
	Reporting Laboratory Type (select one): Public Health	Commercial Other
	Laboratory	Laboratory
21. Nucleic Acid Amplification To	est Result (select one)	
Positive Not Done		Date Regult Departed
I	Date Collected: Month Day Year	Date Result Reported: Month Day Year
☐ Negative ☐ Unknown	Miditi Bay lea	Month Day Teal
☐ Indeterminate		
		Reporting Laboratory Type (select one):
	Enter specimen type: Sputum	— Bublic Health — Commercial —
	OR If not Sputum, enter anatomic code (see list):	Laboratory Laboratory Other
Initial Chest Radiograph and Otl	her Chest Imaging Study	
22A. Initial Chest Radiograph		П
(select one)	Normal Abnormal* (consistent with TB) Not Done	Unknown
	* For ABNORMAL Initial Chest Radiograph: Evidenc	
	Evidenc	e of miliary TB (select one): Yes No Unknown
22B. Initial Chest CT Scan or	□ Normal □ Abnormal* (consistent with TB) □ Not Done	Unknown
Other Chest Imaging Study (select one)	* For ABNORMAL Initial Chest Radiograph: Evidence	e of a cavity (select one): Yes No Unknown
Ciacy (Series erre)		e of miliary TB (select one): Yes No Unknown
	Evidenc	e of fillinary TD (select offe). In fes Into Into Introduction
23. Tuberculin (Mantoux) Skin Te	est	25. Primary Reason Evaluated for TB Disease
at Diagnosis (select one)		(select one)
☐ Positive ☐ Not Done	Date Tuberculin Skin Test (TST) Placed: Millimeters (mm) of induration:	TB Symptoms
Negative Unknown	Month Day Year Of Indulation.	Abnormal Chest Radiograph (consistent with TB)
I Negative I Unknown		
		☐ ☐ Contact Investigation
24. Interferon Gamma Release A	Assay Date Collected:	Targeted Testing
for Mycobacterium tuberculo		Health Care Worker
(select one)		Employment/Administrative Testing
Positive Not Done		☐ Immigration Medical Exam
☐ Negative ☐ Unknown	Test type:	<u> </u>
	Specify	☐ Incidental Lab Result
Indeterminate	орсону	Unknown

REPORT OF VERIFIED CASE OF TUBERCULOSIS 26. HIV Status at Time of Diagnosis (select one) Negative Indeterminate Not Offered Unknown Test Done, Results Unknown Positive Refused If POSITIVE, enter: City/County HIV/AIDS State HIV/AIDS Patient Number: Patient Number: Unknown □No Yes 27. Homeless Within Past Year 28. Resident of Correctional Facility at Time of Diagnosis (select one) (select one) If YES, (select one): If YES, under custody of Immigration and Customs Federal Prison Local Jail Other Correctional Facility Yes Unknown Enforcement? (select one) State Prison ☐ Juvenile Correction Facility Unknown □No Yes 29. Resident of Long-Term Care Facility at Time of Diagnosis (select one) □No Yes Unknown If YES, (select one): Unknown ☐ Nursing Home Residential Facility Alcohol or Drug Treatment Facility Mental Health Residential Facility Under Long-Term Care Facility 30. Primary Occupation Within the Past Year (select one) Retired Not Seeking Employment (e.g. student, homemaker, disabled person) Health Care Worker ☐ Migrant/Seasonal Worker ☐ Correctional Facility Employee ☐ Other Occupation Unemployed Unknown 31. Injecting Drug Use Within Past Year 32. Non-Injecting Drug Use Within Past Year 33. Excess Alcohol Use Within Past Year (select one) (select one) (select one) Unknown □No ☐ Yes Yes Unknown □No Unknown □No Yes 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) None TNF-α Antagonist Therapy End-Stage Renal Disease ☐ 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) ☐ Tourist Visa Not Applicable Immigrant Visa Asylee or Parolee Other Immigration Status Student Visa Family/Fiancé Visa • "U.S.-born" (or born abroad to a parent who was a U.S. citizen) Unknown Employment Visa Refugee . Born in 1 of the U.S. Territories, U.S. Island Areas, or U.S. Outlying Areas 36. Date Therapy Started 37. Initial Drug Regimen (select one option for each drug) No Yes Unk Yes Unk No Yes Unk Moxifloxacin Isoniazid **Ethionamide** ппп Amikacin Rifampin Cycloserine Para-Amino П Pyrazinamide Kanamycin Salicylic Acid Ethambutol Capreomycin Other Specify ППП Ciprofloxacin Streptomycin Other Levofloxacin Rifabutin Specify Rifapentine Ofloxacin Comments:

Patient's Name _				REPORT OF VERIFI	IED CASE
	(Last)	(First)	(M.I.)	OF TUBER	CULOSIS
Street Address					
		(Number, Stre	eet, City, State)	(ZIP CODE)	

ODC	
SAFER · HEALTHIER · PEOPLE	į
SAFER-HEALTHIER-PEOPLE	

REPORT OF VERIFIED CASE OF TUBERCULOSIS

(ZIP CODE)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) ATLANTA, GEORGIA 30333

SAFER·HEALTHIER·PEOPLE						FC	ORM APPROVE	D OMB NO. 092	0-0026 Exp. Dat	ie 05/31/2011
Initial Drug Susc	eptibility	Report					(Fo	ollow U	р Керо	rt – 1)
Year Counted	State Case Numbe City/County Case Numbe									
Submit this repo	rt for all c	ulture- _l	oositive	e cases.						
38. Genotyping Accession Isolate submitted for g		ct one):] No [] Yes						
If YES, genotyping acc	ession number	for episode:	L							
39. Initial Drug Susceptil	oility Testing									
Was drug susceptibilit	y testing done?	(select one)	□No	Yes	Unknown					
If NO or UNKNOWN	l, do not com	plete the re	st of Follo	w Up Report	-1					
If YES, enter date FIRS testing was done: Month Day	ST isolate collect		n drug susc	eptibility	OF	Sputum R not Sputum, en	iter anatomi	c code (see	list):	
40. Initial Drug Susceptil	oility Results (s	elect one opt	ion for each	n drug)						
Isoniazid Rifampin Pyrazinamide Ethambutol Streptomycin Rifabutin Rifapentine Ethionamide Amikacin Kanamycin	Resistant	Susceptible	Not Done	Unknown	Capreomycin Ciprofloxacin Levofloxacin Ofloxacin Moxifloxacin Other Quinolones Cycloserine Para-Amino Salicylic Acid Other Specify Other Specify	Resistant S	Busceptible	Not Done	Unknown I I I I I I I I I I I I I I I I I I I	
Comments:										

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Patient's Name				REPORT OF VERIFIED CASE
	(Last)	(First)	(M.I.)	OF TUBERCULOSIS
Street Address				
		(Number, Str	eet, City, State)	(ZIP CODE)

CDC

Year Counted

State Case Number

REPORT OF VERIFIED CASE OF TUBERCULOSIS

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 (Follow Up Report - 2)

City/County Case Number		
Submit this report for all cases in w	hich the patient was alive a	at diagnosis.
. , ,	If NO, enter reason for not documenting spi No Follow-up Sputum Despite Induction No Follow-up Sputum and No Induction Died No Yes	Patient Refused Patient Lost to Follow-Up Other Specify Unknown Specify Specify Specify
43. Date Therapy Stopped Month Day Year	44. Reason Therapy Stopped or Never State Completed Therapy Lost Uncooperative or Refused Adverse Treatment Event	If DIED, indicate cause of death (select one): Related to TB disease Unrelated to TB disease Dear Related to TB therapy Unknown
	Non-adherence Clini	ically Indicated – other reasons er Specify
	IHS, Tribal HD, or Tribal Corporation	☐ Inpatient Care Only ☐ Unknown ☐ Other
Comments:		

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	REPORT OF VERIFIED CASE
ase No.	OF TUBERCULOSIS

(Last)	(First)	

State C



Patient's Name

REPORT OF VERIFIED CASE OF TUBERCULOSIS

(M.I.)

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

(Follow Up Report - 2)

Case Completion Report - Continued

47. Directly Observed The	rapy (DOT	(select one)								
No, Totally Self-Adm	inistered									
Yes, Totally Directly	Observed									
Yes, Both Directly Ol	bserved an	d Self-Admini	stered							
Unknown										
Number of weeks of dire	ectly obser	ved therapy (E	ют)							
48. Final Drug Susceptibil	ity Testing									
Was follow-up drug sus	ceptibility t	esting done?	(select one)	□No	Yes Unknown					
If NO or UNKNOWN,	do not co	omplete the	rest of Fol							
		•		· · ·	<u>_</u>	¬				
If YES, enter date FINAl testing was done:	L ISOIATE CO	illected for wh	icn arug sus	sceptibility		」Sputum DR			_	
Month Day		Year	_				, enter anato	mic code (se	ee list):	
						,	,	(
			l							
49. Final Drug Susceptibil	ity Results	(select one o	ption for eac	ch drug)						
	Resistant	Susceptible	Not Done	<u>Unknown</u>		Resistant	Susceptible	Not Done	<u>Unknown</u>	
Isoniazid					Capreomycin					
Rifampin					Ciprofloxacin					
Pyrazinamide					Levofloxacin					
Ethambutol					Ofloxacin					
Streptomycin					Moxifloxacin					
Rifabutin					Other Quinolones					
Rifapentine					Cycloserine					
Ethionamide					Para-Amino Salicylic Acid			Ц		
Amikacin					Other					
Kanamycin					Specify					
					Other		Ш			
					Specify				_	
										=
Comments:										
									_	

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