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

Street Address _____ _____
(Number, Street, City, State) (ZIP CODE)

CDC
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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 00/00/0000

1. Date Reported
Month Day Year

2. Date Submitted
Month Day Year

3. Case Numbers

	Year Reported (YYYY)	State Code	Locally Assigned Identification Number	Reason:
State Case Number				
City/County Case Number				
Linking State Case Number				
Linking State Case Number				

4. Reporting Address for Case Counting
City
Within City Limits ☐ Yes ☐ No
County
ZIP CODE —

5. Count Status *(select one)*
- ☐ Count as a TB case
- ☐ Verified Case: Counted by another U.S. area (e.g., county, state)
- ☐ Verified Case: TB treatment initiated in another country *Specify*_____
- ☐ Verified Case: Recurrent TB within 12 months

6. Date Counted
Month Day Year

7. Previous Diagnosis of TB Disease
☐ Yes ☐ No
If YES, enter year of previous TB disease diagnosis:

8. Date of Birth
Month Day Year

9. Sex at Birth
☐ Male ☐ Female

10. Ethnicity *(select one):*
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

11. Race *(select one or more)*
- ☐ American Indian or Alaska Native
- ☐ Asian: *Specify*_____
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander: *Specify*_____
- ☐ White

12. Country of Birth
*Specify*_____

13. Month-Year Arrived in U.S.
Month Year

14. Pediatric TB Patients (<15 years old)
Patient lived outside U.S. for >2 months? ☐ Yes ☐ No ☐ Unknown
If YES, list countries, *specify*: _____
Country of Birth for Primary Guardian(s), *specify*:
Guardian 1_____
Guardian 2_____

15. Status at TB Diagnosis
☐ Alive ☐ Dead
If DEAD, enter date of death: Month Day Year
If DEAD, was TB a cause of death? ☐ Yes ☐ No ☐ Unknown

16. Site of TB Disease *(select all that apply)*
- ☐ Pulmonary
- ☐ Pleural
- ☐ Lymphatic: Cervical
- ☐ Lymphatic: Intrathoracic
- ☐ Lymphatic: Axillary
- ☐ Lymphatic: Other
- ☐ Lymphatic: Unknown
- ☐ Laryngeal
- ☐ Bone and/or Joint
- ☐ Genitourinary
- ☐ Meningeal
- ☐ Peritoneal
- ☐ Other: enter anatomic code(s) *(see list)*:
- ☐ Site not stated

1 2 3

Public reporting burden of this collection of information is estimated to average 35 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0026). Do not send the completed form to this address.

Information contained on this form which would permit identification of any individual has been collected with a guarantee that it will be held in strict confidence, will be used only for surveillance purposes, and will not be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 U.S.C. 242m).

REPORT OF VERIFIED CASE OF TUBERCULOSIS

17. Sputum Smear *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown

Date Collected:
Month Day Year

18. Sputum Culture *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown

Date Collected:
Month Day Year

Date Result Reported:
Month Day Year

Reporting Laboratory Type *(select one)*:
☐ Public Health Laboratory ☐ Commercial Laboratory ☐ Other

19. Smear/Pathology/Cytology of Tissue and Other Body Fluids *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown

Date Collected:
Month Day Year

Enter anatomic code *(see list)*:

Type of exam *(select all that apply)*:
☐ Smear ☐ Pathology/Cytology

20. Culture of Tissue and Other Body Fluids *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown

Date Collected:
Month Day Year

Enter anatomic code *(see list)*:

Date Result Reported:
Month Day Year

Reporting Laboratory Type *(select one)*:
☐ Public Health Laboratory ☐ Commercial Laboratory ☐ Other

21. Nucleic Acid Amplification Test Result *(select one)*

☐ Positive ☐ Not Done ☐ Indeterminate
☐ Negative ☐ Unknown

Date Collected:
Month Day Year

Enter specimen type:
☐ Sputum

or

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

Date Result Reported:
Month Day Year

Reporting Laboratory Type *(select one)*:
☐ Public Health Laboratory ☐ Commercial Laboratory ☐ Other

Initial Chest Radiograph and Other Chest Imaging Study

22A. Initial Chest Radiograph

☐ Normal ☐ Abnormal ☐ Not Done ☐ Unknown

For ABNORMAL Initial Chest Radiograph:
Evidence of a cavity: ☐ Yes ☐ No ☐ Unknown
Evidence of miliary TB: ☐ Yes ☐ No ☐ Unknown

22B. Initial Chest CT Scan or Other Chest Imaging Study

☐ Normal ☐ Abnormal ☐ Not Done ☐ Unknown

For ABNORMAL Initial Chest CT Scan or Other Chest Imaging Study:
Evidence of a cavity: ☐ Yes ☐ No ☐ Unknown
Evidence of miliary TB: ☐ Yes ☐ No ☐ Unknown

23. Tuberculin (Mantoux) Skin Test at Diagnosis *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown

Date Tuberculin Skin Test (TST) Placed:
Month Day Year

Millimeters (mm) of induration:

24. Interferon Gamma Release Assay for *Mycobacterium tuberculosis* at Diagnosis *(select one)*

☐ Positive ☐ Not Done ☐ Indeterminate
☐ Negative ☐ Unknown

Date Collected:
Month Day Year

Test type:
*Specify*_____

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

☐ TB Symptoms
☐ Abnormal Chest Radiograph
☐ Contact Investigation
☐ Targeted Testing
☐ Health Care Worker
☐ Employment/Administrative Testing
☐ Immigration Medical Exam
☐ Incidental Lab Result
☐ Unknown

REPORT OF VERIFIED CASE OF TUBERCULOSIS

26. HIV Status at Time of Diagnosis

☐ 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

☐ No ☐ Yes ☐ Unknown

28. Resident of Correctional Facility at Time of Diagnosis ☐ 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?
☐ No ☐ Yes

29. Resident of Long-Term Care Facility at Time of Diagnosis ☐ 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 Eligible for Employment (e.g. student, homemaker, disabled person)
☐ Correctional Facility Employee ☐ Other Occupation ☐ Unemployed ☐ Unknown

31. Injecting Drug Use Within Past Year

☐ No ☐ Yes ☐ Unknown

32. Non-Injecting Drug Use Within Past Year

☐ No ☐ Yes ☐ Unknown

33. Excess Alcohol Use Within Past Year

☐ No ☐ Yes ☐ Unknown

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

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

35. Immigration Status at First Entry to the U.S.

☐ Not Applicable(U.S.-born) ☐ Tourist Visa ☐ Other Immigration Status
☐ Immigrant Visa ☐ Family/Fiancé Visa ☐ Unknown
☐ Student Visa ☐ Refugee
☐ Employment Visa ☐ Asylee or Parolee

36. Date Therapy Started

Month ☐☐ Day ☐☐ Year ☐☐☐☐

37. Initial Drug Regimen

	No	Yes	Unk
Isoniazid	☐	☐	☐
Rifampin	☐	☐	☐
Pyrazinamide	☐	☐	☐
Ethambutol	☐	☐	☐
Streptomycin	☐	☐	☐
Rifabutin	☐	☐	☐
Rifapentine	☐	☐	☐

	No	Yes	Unk
Ethionamide	☐	☐	☐
Amikacin	☐	☐	☐
Kanamycin	☐	☐	☐
Capreomycin	☐	☐	☐
Ciprofloxacin	☐	☐	☐
Levofloxacin	☐	☐	☐
Ofloxacin	☐	☐	☐

	No	Yes	Unk
Moxifloxacin	☐	☐	☐
Cycloserine	☐	☐	☐
Para-Amino Salicylic Acid	☐	☐	☐
Other	☐	☐	☐
Specify _____			
Other	☐	☐	☐
Specify _____			

Comments:

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

Street Address _____ _____
(Number, Street, City, State) (ZIP CODE)

REPORT OF VERIFIED CASE OF TUBERCULOSIS

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CENTERS FOR DISEASE CONTROL
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ATLANTA, GEORGIA 30333
FORM APPROVED OMB NO. 0920-0026 Exp. Date 00/00/0000

Initial Drug Susceptibility Report

(Follow Up Report – 1)

Year Counted ☐☐☐☐

State Case Number ☐☐☐☐ ☐☐ ☐☐☐☐☐☐☐☐☐

City/County Case Number ☐☐☐☐ ☐☐ ☐☐☐☐☐☐☐☐☐

Submit this report for all culture-positive cases.

38. Genotyping Accession Number

Isolate submitted for genotyping: ☐ No ☐ Yes

If YES, genotyping accession number for episode: ☐☐☐☐☐☐☐☐☐☐☐☐

39. Initial Drug Susceptibility Testing

Was drug susceptibility testing done? ☐ No ☐ Yes ☐ Unknown

If NO or UNKNOWN, do not complete the rest of Follow Up Report –1

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

Month ☐☐ Day ☐☐ Year ☐☐☐☐

Enter specimen type: ☐ Sputum

or

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

40. Initial Drug Susceptibility Results

	Resistant	Susceptible	Not Done	Unknown
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 _____				

Comments:

_____

_____

_____

_____

_____

_____

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

Street Address _____ _____
(Number, Street, City, State) (ZIP CODE)

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REPORT OF VERIFIED CASE OF TUBERCULOSIS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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ATLANTA, GEORGIA 30333
FORM APPROVED OMB NO. 0920-0026 Exp. Date 00/00/0000

Case Completion Report

(Follow Up Report – 2)

Year Counted ☐☐☐☐

State Case Number ☐☐☐☐ ☐☐ ☐☐☐☐☐☐☐☐☐

City/County Case Number ☐☐☐☐ ☐☐ ☐☐☐☐☐☐☐☐☐

Submit this report for all cases in which the patient was alive at diagnosis.

41. Sputum Culture Conversion Documented ☐ No ☐ Yes ☐ Unknown

If YES, enter date specimen collected for first consistently negative sputum culture:

Month ☐☐ Day ☐☐ Year ☐☐☐☐

If NO, enter reason for not documenting sputum culture conversion *(select one)*:

☐ Clinically Improved: No Follow-up Sputum Despite Induction
☐ Patient Refused
☐ Patient Lost to Follow-Up
☐ No Follow-up Sputum Collected
☐ Other *Specify* _____
☐ Died
☐ Unknown

42. Moved

Did the patient move during TB therapy? ☐ No ☐ Yes

If YES, moved to where *(select all that apply)*:

☐ In state, out of jurisdiction *(enter city/county)* *Specify*_____ *Specify*_____

☐ Out of state *(enter state)* *Specify*_____ *Specify*_____

☐ Out of the U.S. *(enter country)* *Specify*_____ *Specify*_____

If moved out of the U.S., transnational referral? ☐ No ☐ Yes

43. Date Therapy Stopped

Month ☐☐ Day ☐☐ Year ☐☐☐☐

44. Reason Therapy Stopped or Never Started *(select one)*

☐ Completed Therapy
☐ Not TB
☐ Lost
☐ Died
☐ Uncooperative or Refused
☐ Other
☐ Adverse Treatment Event
☐ Unknown

If DIED, indicate cause of death *(select one)*:

☐ Related to TB disease
☐ Unrelated to TB disease
☐ Related to TB therapy
☐ Unknown

45. Reason Therapy Extended >12 months *(select all that apply)*

☐ Rifampin resistance
☐ Non-adherence
☐ Clinically Indicated – other reasons
☐ Adverse Drug Reaction
☐ Failure
☐ Other *Specify* _____

46. Type of Outpatient Health Care Provider *(select all that apply)*

☐ Local/State Health Department (HD)
☐ IHS, Tribal HD, or Tribal Corporation
☐ Inpatient Care Only
☐ Unknown
☐ Private
☐ Institutional/Correctional
☐ Other

Comments:

_____

_____

_____

_____

_____

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

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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REPORT OF VERIFIED CASE OF TUBERCULOSIS

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? ☐ 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:

Month ☐☐ Day ☐☐ Year ☐☐☐☐

Enter specimen type: ☐ Sputum

or

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

49. Final Drug Susceptibility Results

	Resistant	Susceptible	Not Done	Unknown
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 _____				

Comments: