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

Street Address ______________________________ (Number, Street, City, State) __________ (ZIP CODE)

REPORT OF VERIFIED CASE OF TUBERCULOSIS

CDC SAFER • HEALTHIER • PEOPLE™

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)*: 1 ☐☐ 2 ☐☐ 3 ☐☐

☐ Site not stated

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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

Drug	No	Yes	Unk	Drug	No	Yes	Unk	Drug	No	Yes	Unk
Isoniazid	☐	☐	☐	Ethionamide	☐	☐	☐	Moxifloxacin	☐	☐	☐
Rifampin	☐	☐	☐	Amikacin	☐	☐	☐	Cycloserine	☐	☐	☐
Pyrazinamide	☐	☐	☐	Kanamycin	☐	☐	☐	Para-Amino Salicylic Acid	☐	☐	☐
Ethambutol	☐	☐	☐	Capreomycin	☐	☐	☐	Other	☐	☐	☐
Streptomycin	☐	☐	☐	Ciprofloxacin	☐	☐	☐	*Specify* ____________			
Rifabutin	☐	☐	☐	Levofloxacin	☐	☐	☐	Other	☐	☐	☐
Rifapentine	☐	☐	☐	Ofloxacin	☐	☐	☐	*Specify* ____________			

Comments:

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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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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

REPORT OF VERIFIED CASE OF TUBERCULOSIS

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:

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

Street Address ____ __________
(Number, Street, City, State) (ZIP CODE)

REPORT OF VERIFIED CASE OF TUBERCULOSIS

CDC
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REPORT OF VERIFIED CASE OF TUBERCULOSIS

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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:

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

REPORT OF VERIFIED CASE OF TUBERCULOSIS

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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:

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