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

Street Address _____ _____ (ZIP CODE)



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

# REPORT OF VERIFIED CASE OF TUBERCULOSIS

**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 *(select one)* ☐ Yes ☐ No

County

ZIP CODE — —

**5. Count Status** *(select one)*

**Countable TB Case**

☐ Count as a TB case

**Noncountable 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 after completion of therapy

**6. Date Counted**

Month | Day | Year

**7. Previous Diagnosis of TB Disease** *(select one)*

☐ Yes ☐ No

If YES, enter year of previous TB disease diagnosis:

**8. Date of Birth**

Month | Day | Year

**9. Sex at Birth** *(select one)*

☐ 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**

"U.S.-born" (or born abroad to a parent who was a U.S. citizen) *(select one)* ☐ Yes ☐ No

Country of birth: *Specify*_____

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

Month | Year

**14. Pediatric TB Patients (<15 years old)**

Country of Birth for Primary Guardian(s): *Specify*

Guardian 1_____

Guardian 2_____

Patient lived outside U.S. for >2 months? *(select one)* ☐ Yes ☐ No ☐ Unknown

If YES, list countries, *specify*: _____

**15. Status at TB Diagnosis** *(select one)*

☐ Alive ☐ Dead

If DEAD, enter date of death: Month | Day | Year

If DEAD, was TB a cause of death? *(select one)* ☐ 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 ☐☐

# 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
☐ Negative ☐ Unknown
☐ Indeterminate

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** *(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 CT Scan or Other Chest Imaging Study: 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)*

☐ 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
☐ Negative ☐ Unknown
☐ Indeterminate

Date Collected: Month Day Year

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

# REPORT OF VERIFIED CASE OF TUBERCULOSIS

**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
- "U.S.-born" (or born abroad to a parent who was a U.S. citizen)
- Born in 1 of the U.S. Territories, U.S. Island Areas, or U.S. Outlying Areas

☐ Immigrant Visa ☐ Tourist Visa ☐ Asylee or Parolee
☐ Student Visa ☐ Family/Fiancé Visa ☐ Other Immigration Status
☐ 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 | ☐ | ☐ | ☐ | Ethionamide | ☐ | ☐ | ☐ | Moxifloxacin | ☐ | ☐ | ☐ |
| Rifampin | ☐ | ☐ | ☐ | Amikacin | ☐ | ☐ | ☐ | Cycloserine | ☐ | ☐ | ☐ |
| Pyrazinamide | ☐ | ☐ | ☐ | Kanamycin | ☐ | ☐ | ☐ | Para-Amino Salicylic Acid | ☐ | ☐ | ☐ |
| Ethambutol | ☐ | ☐ | ☐ | Capreomycin | ☐ | ☐ | ☐ | Other | ☐ | ☐ | ☐ |
| Streptomycin | ☐ | ☐ | ☐ | Ciprofloxacin | ☐ | ☐ | ☐ | *Specify* _____ | | | |
| Rifabutin | ☐ | ☐ | ☐ | Levofloxacin | ☐ | ☐ | ☐ | Other | ☐ | ☐ | ☐ |
| Rifapentine | ☐ | ☐ | ☐ | Ofloxacin | ☐ | ☐ | ☐ | *Specify* _____ | | | |

**Comments:**

_____
_____
_____
_____

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

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

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

# 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 *(select one)*: ☐ No ☐ Yes

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

**39. Initial Drug Susceptibility Testing**

Was drug susceptibility testing done? *(select one)* ☐ No ☐ Yes ☐ Unknown

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

If YES, enter date FIRST specimen collected on which initial 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** *(select one option for each drug)*

| | 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:**

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).

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

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

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

# REPORT OF VERIFIED CASE OF TUBERCULOSIS

## 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** *(select one)* ☐ 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)*:

☐ No Follow-up Sputum Despite Induction
☐ Patient Refused
☐ Patient Lost to Follow-Up
☐ No Follow-up Sputum and No Induction
☐ Other *Specify* _____
☐ Died
☐ Unknown

**42. Moved**

Did the patient move during TB therapy? *(select one)* ☐ 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? *(select one)* ☐ 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 Outpatient
☐ Institutional/Correctional
☐ Other

**Comments:**

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

# 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? *(select one)* ☐ No ☐ Yes ☐ Unknown

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

If YES, enter date FINAL specimen collected on 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** *(select one option for each drug)*

| | 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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