

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 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) 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.)

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



Centers for Disease Control and Prevention National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

FORM APPROVED OMB NO. 0920-0026 Exp. Date 05/31/2014

REPORT OF VERIFIED CASE OF TUBERCULOSIS

Case Completion Report

(Follow Up Report - 2)

Form with fields for Year Counted, State Case Number, and 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. Includes fields for date and reasons for not documenting conversion.

42. Moved. Did the patient move during TB therapy? (select one) [] No [] Yes. Includes fields for where moved and if moved out of the U.S.

43. Date Therapy Stopped. Includes fields for Month, Day, and Year. 44. Reason Therapy Stopped or Never Started (select one) [] Completed Therapy [] Not TB [] Lost [] Uncooperative or Refused [] Adverse Treatment Event [] Died [] Other [] Unknown. Includes field for cause of death if died.

45. Reason Therapy Extended >12 months (select all that apply) [] Rifampin Resistance [] Adverse Drug Reaction [] Non-adherence [] Failure [] Clinically Indicated - other reasons [] Other Specify _____

46. Type of Outpatient Health Care Provider (select all that apply) [] Local/State Health Department (HD) [] Private Outpatient [] IHS, Tribal HD, or Tribal Corporation [] Institutional/Correctional [] Inpatient Care Only [] Other [] Unknown

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.)

State Case No. _____

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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? (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:

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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