

Reporting Severe Adverse Events (Hospitalization or Death) Associated with Treatment of Latent Tuberculosis Infection (LTBI)

National Surveillance for Severe Adverse Events (NSSAE) Data Collection Form

Public reporting burden of this collection of information is estimated to average 1 hour 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/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: PRA (0920-0773)

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 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).

Part 1. To be completed by the medical clerk when a person's condition is suspected to be related to LTBI treatment.

State: _____

Assigned Case Identification Number: (2digit state abbreviation-5 digit county FIPS-001) _____

Form completed by:

CDC phone interview _____ CDC on-site investigator _____ On-site local staff _____

Name of person who reported the case: _____

Phone number: _____

Corresponding health department: _____

Name of contact in corresponding health department (if different than above): _____

Phone number: _____

Date CDC notified _____ **Reported to FDA/MedWatch: Yes** _____ **No** _____

SOURCE OF REPORT

Name of setting where TLTBI was prescribed: _____

County/city/state: _____

Facility type: Health department _____ Private provider _____ HMO _____

Other (specify): _____

Location where severe adverse event was detected: Health department _____

Private provider _____ HMO _____

Other (specify): _____

BASIC PATIENT AND ILLNESS DESCRIPTION

Age at time of starting LTBI treatment: _____ **Sex:** Male _____ Female _____

Ethnicity (select one): Hispanic or Latino _____ Not Hispanic or Latino: _____

Race (select one or more): American Indian/Alaska Native _____ Asian (specify) _____

Black/African American _____ Native Hawaiian/Other Pacific Islander (specify) _____

White _____

Unknown (Please explain): _____

Country of birth: United States: Yes _____ No _____

Other countries Yes _____ No _____ If yes, Specify _____

Year arrived in United States _____

Residence in other country/countries: Yes _____ No _____

Identify country/countries: _____