Form Approved
OMB No. 0920-0773
Expiration Date: xx/xx/xxxx

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

Part 2. To be completed by the nurse
****The information requires input from the medical clerk by searching the records of the admitting hospital and other hospitals where the patient might have been evaluated in the past.***

Able to speak English? Yes _____ No_____
If No, what is the primary language?_____
Preferred language (please answer even if patient speaks English):_____
Language in which follow-up and monitoring visits were conducted_____

Adverse event leading to hospitalization or death associated with LTBI treatment:
Anaphylaxis ____ Metabolic acidosis ____ Other, specify _____
Liver injury ____ Severe dermatitis ____

***Admission to hospital:** Yes _____No _____ Unknown _____
If Yes: Date:_____ Date discharged:_____
Reason:_____

Severity of adverse event outcome: (Check all that apply)
Still Sick _____ Full recovery _____ Pending _____
Recovery with residual effects _____
Evaluated for possible liver transplant but did not have transplant_____
Liver transplant _____ Unknown _____
Death: Yes ___ No _____ Date died: _____

LTBI DIAGNOSIS AND TREATMENT

Reason(s) for tuberculin skin test (TST)/Interferon Gamma Release Assay (IGRA) for LTBI
Check all that apply:
Contact to person with TB disease _____ Recently (past 2 years)? _____
Risk factors for TB
HIV infection: _____ HIV test date: _____
Diabetes _____ Renal failure _____ Organ transplant _____
Cancer or leukemia _____ Abnormal chest radiograph_____ Chronic steroid administration _____
Immunosuppressive therapy other than chronic steroid administration ____, Specify_____
Excessive alcohol use within the past year_____
Illicit drug use within the past year_____
Unknown_____

Congregational setting: Jail ___ Prison ___ Homeless shelter ___
Long-term care facility___ Other, specify_____
Occupational risk of exposure _____
health care worker_____, correctional facility worker_____, migrant/seasonal worker_____
Routine/administrative work requirement _____
Foreign born_____
School admission requirement_____
Unknown _____

TST: Date TST placed: _____ Date TST read: _____
TST result: _____mm Positive___ Negative ___
Converter (documented negative baseline TST)? Yes_____ No_____

If IGRA performed, which test?
QuantiFERON TB Gold test (QFT-G)_____
QuantiFERON-TB Gold-in-tube test (QFT-GIT)_____
T-Spot TB test_____

Date of IGRA performed: _____
Test result*:
Result: Positive_____ Negative_____Indeterminate_____
Quantitative results (list all available values):_____
Converter (documented negative baseline IGRA)? (Yes/No_____
*Refer to the following guideline to interpret results: CDC. Updated Guidelines for Using Interferon Gamma Release Assays to Detect Mycobacterium tuberculosis Infection --- United States, 2010, MMWR, Recommendations and Reports, June 25, 2010 / 59(RR05);1-25
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5905a1.htm?s_cid=rr5905a1_e

LTBI TREATMENT REGIMEN(S): Please specify the medication(s) taken by the patient.

Medication	Daily or twice weekly	Initial regimen dosage (mg)	Second regimen dosage (mg)
INH			
RIF			
PZA			

Initial TLTBI start date: _____ End date: _____
Second TLTBI start date: _____ End date: _____
Medication lot number: _____
Medication manufacturer: _____
Patient's weight: _____ lbs