|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Photo  OMB No. 1405-0113  EXPIRATION DATE: xx/xx/xxxx  ESTIMATED BURDEN: 20 MINUTES  (See Page 2 – Back of Form)  U.S. Department of State  **TUBERCULOSIS WORKSHEET**  **For use with DS-2054** | | | | | | | | |  |
| Name *(Last, First, MI)* | | | | | | | | | Age |
| Birth Date *(mm-dd-yyyy)* | | | | Passport Number | | | Alien *(Case)* Number | | |
| 1. **Test for Cell-Mediated Immunity to Tuberculosis**   *Required for applicants 2 through 14 years of age where WHO-estimated TB rate ≥20 per 100,000 and contacts; perform one type only.* | | | | | | | | | |
| TST Date applied *(mm-dd-yyyy)* | | | | QFT Nil Value: IU  TB Response: TB minus nil IU/ml  T-Spot Nil Value: Number of cells  TB Response: Higher of  Panel A or Panel B minus nil value | | | | | |
| Result *(mm)*  IGRA Date drawn *(mm-dd-yyyy)*  Positive  Negative  Indeterminant, Borderline, or Equivocal | | | |
| 1. **Chest X-Ray Indication** *(Mark all that apply)* | | | | | Date Chest X-Ray Taken *(mm-dd-yyyy)* | | | | |
| Chest X-Ray not indicated  Age >15 years  Signs or symptoms of tuberculosis | Known HIV infection  TST ≥10 mm or IGRA positive  Contact: TST > 5 mm or IGRA positive | | | |
| **3. Chest X-Ray Findings**  Normal Findings | | Abnormal Findings *(Indicate category and finding, checking all that apply in the tables below)* | | | | | | | |  |
| **Can Suggest Tuberculosis *(Need Smears and Cultures)*** | | | | | | **No Sputum Specimens Required** | | | |
| Infiltrate or consolidation  Cavitary lesion  Nodule or mass with poorly defined margins (such as tuberculoma)  Pleural effusion (perform lateral or decubitus radiograph or ultrasound, if needed) | | | Hilar/mediastinal adenopathy  Miliary findings  Discrete linear opacity  Discrete nodule(s) without calcification  Volume loss or retraction  Other | | | **Mark as Class B Other on DS 2054**  Cardiac  Musculoskeletal  Other, specify in Remarks | | **Do not mark as Class B Other on DS 2054**  Pleural thickening  Diaphragmatic tenting  Calcified pulmonary nodule(s)  Calcified lymph node(s) | |
| Remarks  Radiologist’s Name *(Printed)* Radiologist's Signature *(Required)* Date Interpreted *(mm-dd-yyyy)* | | | | | | | | | |
| **4. Sputum Smears and Cultures Decision**  No, not indicated - Applicant has no signs or symptoms of TB, no known HIV infection, and:  X-ray Normal or ‘No specimens required' and test for cell-mediated immunity to TB negative *(if performed)*  X-ray Normal or ‘No specimens required’ and test for cell-mediated immunity to TB positive *(if performed)*  Yes, are indicated - Applicant has (*Mark all that apply)*:  Signs or symptoms of TB  Chest X-ray suggests TB  Known HIV infection  End of treatment cultures | | | | | | | | | |
| **5. Sputum Smears and Cultures Results**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Sputum  Smear  Results | Date specimen obtained *(mm-dd-yyyy)* | Date specimen reported  *(mm-dd-yyyy)* | Positive | Negative | | 1. |  |  |  | | 2. |  |  |  | | 3. |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Sputum  Culture  Results | Date specimen obtained  *(mm-dd-yyyy)* | Date specimen reported *(mm-dd-yyyy)*  \*Date of exam on DS 2054 | Positive | Negative | NTM | Contaminated | | 1. |  |  |  |  |  | | 2. |  |  |  |  |  | | 3. |  |  |  |  |  | | | | | | | | | | |
| **6. Tuberculosis Classification**  Applicants may have more than one TB Classification. However, they cannot be classified as both Class B1 TB and Class B2 TB. In addition, applicants cannot be classified as Class B3 TB, Contact Evaluation if they are Class A or Class B1 TB, Extrapulmonary.  **No TB Classification**  CXR not suggestive of tuberculosis, no signs or symptoms, no known HIV infection, TST or IGRA negative (if performed), not a contact  **Class A**  Applicant has tuberculosis disease  **Class B1 TB, Pulmonary**  CXR suggests tuberculosis, or signs and symptoms, or known HIV infection and sputum smears and cultures are negative and not a clinically diagnosed case.  **Class B1 TB, Extrapulmonary**  Applicants with evidence of extrapulmonary tuberculosis. The anatomic site of infection should be documented.  Anatomic Site of Disease  No treatment  Current treatment  Completed treatment  **Class B2 TB, LTBI Evaluation**  Applicants who have a tuberculin skin test ≥10 mm or positive IGRA but otherwise have a negative evaluation for tuberculosis. Contacts with TST ≥5 mm or positive IGRA should receive this classification (if they are not already Class B1 TB, Pulmonary).  No LTBI treatment  Current LTBI treatment *(Indicate medications in Part 7)*  Completed LTBI treatment *(Indicate medications in Part 7)*  **Class B3 TB, Contact Evaluation**  Applicants who are a recent contact of a known tuberculosis case.  No preventive treatment  Current preventive treatment *(Indicate medications in Part 7)*  Completed preventive treatment *(Indicate medications in Part 7)*  Source Case:  Name  Alien Number  Relationship to Contact  Date Contact Ended *(mm-dd-yyyy)*  Type of Source Case TB *(Mark only one and attach DST results)*  Pansusceptible TB  MDR TB (resistant to at least INH and rifampin)  Drug-resistant TB other than MDR TB Culture negative  Culture results not available | | | | | | | | | |
| Remarks | | | | | | | | | |
| **7. Previous Tuberculosis Diagnosis and Treatment History for Applicants Diagnosed or Treated Through Panel Physician**  Complete this section only if one of the following is true *(mark appropriate option)*:  Applicant was diagnosed with tuberculosis disease by the panel physician  Applicant was on tuberculosis treatment at the time of presentation for their medical examination  How was the diagnosis made: Positive laboratory tests Clinical diagnosis   |  |  | | --- | --- | | Diagnostic Chest Radiograph | | | Facility performing chest radiograph:  Date Radiograph obtained *(mm-dd-yyyy):* | | | Findings Present | | | Infiltrate or consolidation  Cavitary lesion  Nodule or mass with poorly defined margins (such as tuberculoma)  Hilar/mediastinal adenopathy  Pleural effusion | Miliary findings  Discrete linear opacity  Discrete nodule(s) without calcification  Volume loss or retraction  Other  Normal or no findings suggestive of tuberculosis |   Sputum Smear Results   |  |  |  |  | | --- | --- | --- | --- | | Date specimen obtained *(mm-dd-yyyy)* | Date specimen reported  *(mm-dd-yyyy)* | Positive | Negative | | 1. |  |  |  | | 2. |  |  |  | | 3. |  |  |  |   Sputum Culture Results   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Date specimen obtained  *(mm-dd-yyyy)* | Date specimen reported  *(mm-dd-yyyy)* | Positive | Negative | NTM | Contaminated | | 1. |  |  |  |  |  | | 2. |  |  |  |  |  | | 3. |  |  |  |  |  |   Drug Susceptibility Test Results. Attach with DS Forms.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Method of DST: | | | Date specimen obtained  *(mm-dd-yyyy)* | Date DST reported  *(mm-dd-yyyy)* | | MGIT | Agar | LJ |  |  |  |  |  |  |  | | --- | --- | --- | --- | |  | Drug | Susceptible | Resistant | | Required for first-line DST | Isoniazid |  |  | | Rifampin |  |  | | Ethambutol |  |  | | Pyrazinamide |  |  | | Required for multidrug-resistant cases | Ethionamide |  |  | | Amikacin |  |  | | Capreomycin |  |  | | Para-aminosalycilic acid (PAS) |  |  | | Fluoroquinolone, specify: |  |  | |  | Other, specify: |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | | | | | | | | | | |
| **7. Previous Tuberculosis Diagnosis and Treatment History for Applicants Diagnosed or Treated Through Panel Physician, Continued**  Were molecular tests used in addition to the required sputum smears, cultures, and DST:  No  Yes *(mark all that apply)*:   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Molecular Test | Mycobacterium tuberculosis | | Rifampin  Resistance | | Isoniazid  Resistance | | Second-Line Test | | Positive | Negative | Positive | Negative | Positive | Negative | | Hain Line Probe Assay |  |  |  |  |  |  | Performed, attach results | | GeneXpert |  |  |  |  |  | | |   Tuberculosis Treatment   |  |  |  |  | | --- | --- | --- | --- | | Treating physician or institution  DGMQ-Designated DOT site:  Non-DGMQ-Designated DOT site: | | | | | Drug | Dosage | Start Date *(mm-dd-yyyy)* | End Date *(mm-dd-yyyy)* | | Isoniazid |  |  |  | | Rifampin |  |  |  | | Ethambutol |  |  |  | | Pyrazinamide |  |  |  | | Other, specify: |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | | | | | | | | | | |
| **PAPERWORK REDUCTION ACT AND CONFIDENTIALITY STATEMENTS**  **PAPERWORK REDUCTION ACT STATEMENT**  Public reporting burden for this collection of information is estimated to average 20 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to [PRA\_BurdenComments@state.gov](mailto:PRA_BurdenComments@state.gov)  **CONFIDENTIALITY STATEMENT**  AUTHORITIES: The information asked for on this form is requested pursuant to Section 212(a) and 221(d) and as required by Section 222 of the Immigration and Nationality Act. Section 222(f) provides that the records of the Department of State and of diplomatic and consular offices of the United States pertaining to the issuance and refusal of visas or permits to enter the United States shall be considered confidential and shall be used only for the formulation, amendment, administration, or enforcement of the immigration, nationality, and other laws of the United States. Certified copies of such records may, in the discretion of the Secretary of State, be made available to a court provided the court certifies that the information contained in such records is needed in a case pending before the court.  PURPOSE: The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.  ROUTINE USES: If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue a social security number. The information provided may also be released to federal agencies for law enforcement, counterterrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies who may need the information to administer or enforce U.S. laws. More information on the Routine Uses for this collection can be found in the System of Records Notice State-24, Medical Records. | | | | | | | | | |