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U.S. Department of State  
**TUBERCULOSIS WORKSHEET**  
 For use with DS-2054

OMB No. 1405-0113  
 EXPIRATION DATE: x x / x x / x x x x  
 ESTIMATED BURDEN: 20 MINUTES  
 (See Page 2 – Back of Form)

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  $\geq 20$  per 100,000 and contacts; perform one type only.

<input type="checkbox"/> TST	Date applied (mm-dd-yyyy) _____	<input type="checkbox"/> QFT	Nil Value: IU _____
	Result (mm) _____		TB Response: TB minus nil IU/ml _____
<input type="checkbox"/> IGRA	Date drawn (mm-dd-yyyy) _____	<input type="checkbox"/> T-Spot	Nil Value: Number of cells _____
<input type="checkbox"/> Positive			TB Response: Higher of
<input type="checkbox"/> Negative			Panel A or Panel B minus nil value _____
<input type="checkbox"/> Indeterminant, Borderline, or Equivocal			

**2. Chest X-Ray Indication (Mark all that apply)**

<input type="checkbox"/> Chest X-Ray not indicated	<input type="checkbox"/> Known HIV infection
<input type="checkbox"/> Age $\geq 15$ years	<input type="checkbox"/> TST $\geq 10$ mm or IGRA positive
<input type="checkbox"/> Signs or symptoms of tuberculosis	<input type="checkbox"/> Contact: TST $\geq 5$ mm or IGRA positive

Date Chest X-Ray Taken (mm-dd-yyyy)

**3. Chest X-Ray Findings**

<input type="checkbox"/> Normal Findings	<input type="checkbox"/> Abnormal Findings (Indicate category and finding checking all that apply in the tables below)
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**Can Suggest Tuberculosis (Need Smears and Cultures)**

<input type="checkbox"/> Infiltrate or consolidation	<input type="checkbox"/> Hilar/mediastinal adenopathy
<input type="checkbox"/> Cavitary lesion	<input type="checkbox"/> Miliary findings
<input type="checkbox"/> Nodule or mass with poorly defined margins (such as tuberculoma)	<input type="checkbox"/> Discrete linear opacity
<input type="checkbox"/> Pleural effusion (perform lateral or decubitus radiograph or ultrasound, if needed)	<input type="checkbox"/> Discrete nodule(s) without calcification
	<input type="checkbox"/> Volume loss or retraction
	<input type="checkbox"/> Other

**No Sputum Specimens Required****Mark as Class B Other on DS 2054**

<input type="checkbox"/> Cardiac
<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Other, specify in Remarks

**Do not mark as Class B Other on DS 2054**

<input type="checkbox"/> Pleural thickening
<input type="checkbox"/> Diaphragmatic tenting
<input type="checkbox"/> Calcified pulmonary nodule(s)
<input type="checkbox"/> Calcified lymph node(s)

Remarks

Radiologist's Name (Printed)

Radiologist's Signature (Required)

Date Interpreted (mm-dd-yyyy)

**4. Sputum Smears and Cultures Decision**

<input type="checkbox"/> No, not indicated - Applicant has no signs or symptoms of TB, no known HIV infection, and:
<input type="checkbox"/> X-ray Normal or 'No specimens required' and test for cell-mediated immunity to TB negative (if performed)
<input type="checkbox"/> X-ray Normal or 'No specimens required' and test for cell-mediated immunity to TB positive (if performed)
<input type="checkbox"/> Yes, are indicated - Applicant has (Mark all that apply):
<input type="checkbox"/> Signs or symptoms of TB
<input type="checkbox"/> Chest X-ray suggests TB
<input type="checkbox"/> Known HIV infection
<input type="checkbox"/> 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  $\geq 10$  mm or positive IGRA but otherwise have a negative evaluation for tuberculosis. Contacts with TST  $\geq 5$  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**

- |   |   |
|---|---|
| <input type="checkbox"/> Infiltrate or consolidation                                      | <input type="checkbox"/> Miliary findings                                 |
| <input type="checkbox"/> Cavitory lesion  | <input type="checkbox"/> Discrete linear opacity                          |
| <input type="checkbox"/> Nodule or mass with poorly defined margins (such as tuberculoma) | <input type="checkbox"/> Discrete nodule(s) without calcification         |
| <input type="checkbox"/> Hilar/mediastinal adenopathy                                     | <input type="checkbox"/> Volume loss or retraction                        |
| <input type="checkbox"/> Pleural effusion   | <input type="checkbox"/> Other  |
|   | <input type="checkbox"/> 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)
<input type="checkbox"/> MGIT <input type="checkbox"/> Agar <input type="checkbox"/> LJ		

	Drug	Susceptible	Resistant
Required for first-line DST	Isoniazid		
	Rifampin		
	Ethambutol		
	Pyrazinamide		
Required for multidrug-resistant cases	Ethionamide		
	Amikacin		
	Capreomycin		
	Para-aminosalicylic 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.