



# TUBERCULOSIS WORKSHEET

Photo	Surnames		Given Names		Age
	Birth Date (mm-dd-yyyy)	Document Type	Document Number	Case or Alien Number	

**1. Test for Cell-Mediated Immunity to Tuberculosis**  
See Tuberculosis Technical Instructions, when required, perform one type only.

TST Date applied (mm-dd-yyyy) \_\_\_\_\_  
Results (mm) \_\_\_\_\_

IGRA Date drawn (mm-dd-yyyy) \_\_\_\_\_

Positive  
 Negative  
 Indeterminate, Borderline, or Equivocal

If IGRA performed, mark which test:  
 Quantiferon  
 T-Spot

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

Chest X-Ray not indicated  
 Age ≥ 15 years  
 Signs or symptoms of tuberculosis

Known HIV infection  
 TST ≥ 10 mm or IGRA positive  
 TB Case Contact: TST ≥ 5 mm or IGRA positive

History of Tuberculosis

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

**3. Chest X-Ray Findings (for radiologist to complete)**

Normal Findings  
 Abnormal Findings (Indicate category and finding, marking all that apply in the tables below)

Suggests Tuberculosis (Need Smears and Cultures)		Does Not Need Smears and Cultures	
<input type="checkbox"/> Infiltrate or consolidation	<input type="checkbox"/> Miliary findings	<b>Mark as Class B Other on DS-2054</b>	<b>Do Not Mark as Class B Other on DS-2054</b>
<input type="checkbox"/> Reticular markings suggestive of fibrosis	<input type="checkbox"/> Discrete linear opacity		
<input type="checkbox"/> Cavitary lesion	<input type="checkbox"/> Discrete nodule(s) without calcification		
<input type="checkbox"/> Nodule(s) or mass with poorly defined margins (such as tuberculoma)	<input type="checkbox"/> Volume loss or retraction		
<input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Irregular thick pleural reaction		
<input type="checkbox"/> Hilar/mediastinal adenopathy	<input type="checkbox"/> Other		

Radiologist's Remarks

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Radiologist's Name (Printed) \_\_\_\_\_ Radiologist's Signature (Required) \_\_\_\_\_ Date Interpreted (mm-dd-yyyy) \_\_\_\_\_

**4. Sputum Smears and Cultures Decisions**

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) *Use as 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 tuberculosis 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 tuberculosis 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
- Started but did not finish extrapulmonary 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).

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> No LTBI treatment                         | If treated, LTBI treatment:                                    | If treated, mark LTBI regimen:       |
| <input type="checkbox"/> Current LTBI treatment                    | <input type="checkbox"/> LTBI treatment by panel physician     | <input type="checkbox"/> Isoniazid   |
| <input type="checkbox"/> Completed LTBI treatment                  | <input type="checkbox"/> LTBI treatment by non-panel physician | <input type="checkbox"/> Rifampin    |
| <input type="checkbox"/> Started but did not finish LTBI treatment | Dates of treatment _____ to _____                              | <input type="checkbox"/> 3HP         |
|  |  | <input type="checkbox"/> Other _____ |

- Class B3 TB, Contact Evaluation**  
Applicants who are a recent contact of a known tuberculosis case.
- No preventive treatment
- Window Prophylaxis
  - Isoniazid     Rifampin     3HP     Other \_\_\_\_\_

Source Case:

Name \_\_\_\_\_

Case or Alien Number, if known \_\_\_\_\_

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
- DST results not yet available

Remarks

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**7. History of Class A TB**

Complete this section only if one of the following is true (*mark appropriate option*):

- Applicant was previously diagnosed with Class A TB 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 ( <i>mm-dd-yyyy</i> ): _____	
Findings Present	
<input type="checkbox"/> Normal or no findings suggestive of tuberculosis	<input type="checkbox"/> Hilar/mediastinal adenopathy
<input type="checkbox"/> Infiltrate or consolidation	<input type="checkbox"/> Miliary findings
<input type="checkbox"/> Reticular marking suggestive of fibrosis	<input type="checkbox"/> Discrete linear opacity
<input type="checkbox"/> Cavitory lesion	<input type="checkbox"/> Discrete nodule(s) without calcification
<input type="checkbox"/> Nodule(s) or mass with poorly defined margins (such as tuberculoma)	<input type="checkbox"/> Volume loss or retraction
<input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Irregular thick pleural reaction
	<input type="checkbox"/> Other

**Sputum Smear Results at Diagnosis**

Date specimen obtained ( <i>mm-dd-yyyy</i> )	Date specimen reported ( <i>mm-dd-yyyy</i> )	Positive	Negative
1.			
2.			
3.			

**Sputum Culture Results at Diagnosis**

Date specimen obtained ( <i>mm-dd-yyyy</i> )	Date specimen reported ( <i>mm-dd-yyyy</i> )	Positive	Negative	NTM	Contaminated
1.					
2.					
3.					

**Drug Susceptibility Test Results**

Method of DST:	Date specimen obtained ( <i>mm-dd-yyyy</i> )	Date DST reported ( <i>mm-dd-yyyy</i> )
<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 ( <i>PAS</i> )		
	Fluoroquinolone, specify: _____		
	Other, specify: _____		

**7. History of Class A TB, 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	
<input type="checkbox"/> Hain Line Probe Assay							<input type="checkbox"/> Performed, attach results
<input type="checkbox"/> GeneXpert							
<input type="checkbox"/> Other _____							

**Tuberculosis Treatment**

Treating physician or institution

Designated DOT site: \_\_\_\_\_

Non-Designated DOT site: \_\_\_\_\_

Drug	Dosage	Start Date (mm-dd-yyyy)	End Date (mm-dd-yyyy)
Isoniazid			
Rifampin			
Ethambutol			
Pyrazinamide			
Other, specify:			

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**PAPERWORK REDUCTION ACT STATEMENT**

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