**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 (P920-0773)

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_