Form Approved
OMB No. 0920-0773
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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

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: _____