The EDN Tuberculosis Follow-Up Worksheet for Newly-Arrived Persons with Overseas Tuberculosis Classifications

A. Demographic					
A1. Name (Last, First, Middle):	A2. Alien #:		A3. Visa type:	A4. Initial U.S.	entry date:
A5. Age: A6. Sex: A7. DOB:			A8. TB Class Based on <i>Technical Instructions for Panel Physicians</i> :		
A9. Country of examination:			A10. Country of birth:		
A11a. Name in care of:			A12a. Sponsor agency name:		
A11b. Phone number:			A12b. Phone number:		
A11c. Address:			A12c. Address:		
B. Jurisdictional Information					
B1. Arrival jurisdiction: B2. Current jurisdiction:					
C. U.S. Evaluation					
C1. Date of first U.S. test or provider/cli	nic visit:/	/			
Mantoux Tuberculin Skin Test (TST) in U.S.			Interferon-Gamma Release Assay (IGRA) in U.S.		
C2a. Was a TST administered in the U.S.?			C3a. Was IGRA performed?	Yes I	No Unknown
Yes No Unknown			If YES, C3b. Date collected:	//	Date unknown
/f YES, C2b. TST placement date://				IUs/Sp	ots
Placement date uknown			C3c. IGRA brand:	QuantiFERON®	⊚ ∏т-ѕрот
C2c. TST mm: Unknown			Other (specify):		
C2d. TST interpretation:					
Positive Negative			C3d. Result: Positive Negative Indeterminate, Borderline, or		
			Invalid Unknown Equivocal		
C2e. History of Previous Posi	tive TST:		C3e. History of previous positive IGRA:		
Yes No Unknown			Yes No Unknown		
U.S Review of Pre-Immigration	on CXR		U.S. Domestic CXR		Comparison
C4. Pre-immigration CXR available?		C6a. U	.S. domestic CXR done?		C8. U.S. domestic
Yes No Unknown			es 🗌 No 📄 Unknown		CXR comparison to pre-immigration CXR:
		If YES	L L L If YES , C6b. Date of U.S. CXR:///		
C5. U.S. interpretation of pre-immigration CXR:		C7. In	C7. Interpretation of U.S. CXR:		
Normal (Negative for TB)		Normal (Negative for TB)			
		Abnormal			
Suggestive of TB		Suggestive of TB			
Non-TB Condition			Non-TB Condition		
Poor Quality/Not Interpretable		Pc	Poor Quality/Not Interpretable		
Unknown		Ur	hknown		
Public reporting burden of this collection of information is estimated to average 30 minutes per individual, 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 Information Collection Review Office, 1600 Clifton Road NE, MS D¬74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).					

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U.S. Review of Pre-Immigration Treatment C9a. Completed treatment pre-immigration? Unknown If YES, C9b. Treated for TB disease Treated for LTBI Treated, but unknown if TB disease or LTBI	C10a. Arrived to the U.S. on treatment? Yes No Unknown If YES, C10b. Treated for TB disease Treated fo				
If YES , C9b. Treated for TB disease Treated for LTBI	Yes No Unknown				
If YES , C9b. Treated for TB disease Treated for LTBI					
Treated, but unknown if TB disease or LTBI	If YES, C10b. Treated for TB disease Treated fo	Unknown			
		r LTBI			
If Treated for TB disease,					
Treatment completed prior to panel physician examination	C10c. Start date:// Start date unkno	own			
Treatment completed after panel physician diagnosis (DS 3030)					
At designated DOT site	C11a: Pre-Immigration treatment concerns?				
At non-designated DOT site					
Other, specify:	If YES , C11b. Select all that apply:				
C9c. Treatment start date:// Start date unknown	Treatment duration too short				
C9d. Treatment end date:// End date unknown	Incorrect treatment regimen				
C9e. Report of treatment administered prior to panel physician	Inadequate information provided				
examination:	Lack of adequate diagnostics				
Treatment documented on overseas medical history form (DS 3026)	Unknown DOT/adherence status				
Documented on DS forms & patient reported at panel physician examination	Other, please specify:				
After U.S. arrival only, patient verbally reported					
Unknown					
C9f. Standard TB treatment regimen was administered?					
\square Yes \square No \square Unable to verify					
	_				
C12. U.S. Microscopy/Bacteriology* Sputa collected in U.S.? Yes	No *Covers all results regardless of sputa collection me	ethod.			
# Date Collected AFB Smear Sp	utum Culture Drug Susceptibility Testing				
Positive Negative NTM	MTB Complex MDR-TB Mono-RIF				
│ ¹ │ <u> </u>	d Negative Mono-INH Other DR				
	Unknown No DR Not Done				
	MTB Complex MDR-TB Mono-RIF				
2 // └ └ └ └ └ └ └ Contaminat	ed Negative Mono-INH Other DR				
Not Done	Unknown No DR Not Done				
	MTB Complex MDR-TB Mono-RIF				
³ / □	ed Negative Mono-INH Other DR				
Not Done Unknown Not Done	Unknown No DR Not Done				
D. Evaluation Disposition in U.S.					
D1a. Evaluation disposition date in U.S.:// D1b. Sta	e/jurisdiction of evaluation disposition in U.S.:				
D2a. Evaluation disposition in U.S.:					
Completed evaluation Initiated Evaluation / Not completed Did not initate evaluation					
D2b. If evaluation was completed, D2c. If evaluation was NOT completed, why not? Select all that apply.					
was treatment recommended?					
Unknown U Other, specify:					
D3. Diagnosis Class 0 - No TB exposure, not infected or Class 1 - TB exposure, no evidence of infection					
Class 2 - TB infection, no disease					
Class 4 - TB, inactive disease	Pulmonary Extra-pulmonary Both sites				
D2b. If evaluation was completed, was treatment recommended? Yes No LTBI D2c. If evaluation was NOT Not Located Lost to Follow-Up	ompleted, why not? Select all that apply. Moved within U.S., transferred to:				

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Alien #				
D4. If diagnosed with TB disease: State Cas	se Number:			
RVCT # unknown* RVCT Reported*	Year State RVCT # / TBLISS #			
TBLISS # unknown*				
City/County Ca	se Number:			
	Year State RVCT # / TBLISS #			
*Note: Either the RVCT or TBLISS number may be reported.				
E. U.S. Treatment for TB Disease or TB Infection				
	nown			
E1b. If NO , specify the reason. Select all that apply:	-up Moved within U.S., transferred to:			
	State/jurisdiction			
Currently on treatment Treatment not Contraindication for treatment Iocal clinic gui	t offered based on Unknown idelines Other, specify:			
E1c. <i>If</i> YES : Treated for TB disease Treated for LTBI				
	ction of treatment in U.S.:			
E4. Specify initial LTBI regimen:				
Isoniazid (9 months; 9H)				
Isoniazid (6 months; 6H)				
Isoniazid/Rifapentine (3 months; 3HP)				
Isoniazid/Rifampin (INH+RIF; 4 months)				
Rifampin (4 months; 4R)				
Isoniazid/Rifampin/Ethambutol/Pyrazinamide (RIPE; 2 mor	iths; suspected TB disease)			
Unknown				
Other, specify:				
E5a. U.S. treatment completed:	Unknown			
If NO , E5b. Specify the reason. Select all that apply:	_			
Patient declined against medical advice	to follow-up Moved within U.S., transferred to:			
	ed outside the U.S. Unknown State/ jurisdiction			
Dying (treatment stopped because of Adve imminent death, regardless of cause of	rse effect Other, specify:			
	B disease Developed TB [For			
	nosed with LTBI]			
Specify reason therapy stopped:				
F. Evaluation Site Information	G. Treatment Site Information			
Provider's Name:	Provider's Name:			
Clinic Name:	Clinic Name:			
Telephone Number:	Telephone Number:			
	Same as evaluation site information			
H. Comments				