

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/clinic 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.? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES , C2b. TST placement date: _____/_____/_____ <input type="checkbox"/> Placement date known C2c. TST mm: _____ <input type="checkbox"/> Unknown C2d. TST interpretation: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown C2e. History of Previous Positive TST: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | C3a. Was IGRA performed in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES , C3b. Date collected: _____/_____/_____ <input type="checkbox"/> Date unknown _____ IUs/Spots C3c. IGRA brand: <input type="checkbox"/> QuantiFERON® <input type="checkbox"/> T-SPOT <input type="checkbox"/> Other, specify: _____ C3d. Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate, Borderline, or Equivocal <input type="checkbox"/> Invalid <input type="checkbox"/> Unknown C3e. History of previous positive IGRA: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| U.S. Review of Pre-Immigration CXR | | U.S. Domestic CXR | | Comparison |
| C4. Pre-immigration CXR available? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | C6a. U.S. domestic CXR done? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES , C6b. Date of U.S. CXR: _____/_____/_____ | | C8. U.S. domestic CXR comparison to pre-immigration CXR: <input type="checkbox"/> Stable <input type="checkbox"/> Worsening <input type="checkbox"/> Improving <input type="checkbox"/> Unknown |
| C5. U.S. interpretation of pre-immigration CXR: <input type="checkbox"/> Normal (Negative for TB) <input type="checkbox"/> Abnormal <input type="checkbox"/> Suggestive of TB <input type="checkbox"/> Non-TB Condition <input type="checkbox"/> Poor Quality/Not Interpretable <input type="checkbox"/> Unknown | | C7. Interpretation of U.S. CXR: <input type="checkbox"/> Normal (Negative for TB) <input type="checkbox"/> Abnormal <input type="checkbox"/> Suggestive of TB <input type="checkbox"/> Non-TB Condition <input type="checkbox"/> Poor Quality/Not Interpretable <input type="checkbox"/> Unknown | | |

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Alien # _____

U.S. Review of Pre-Immigration Treatment

C9a. Completed treatment pre-immigration? Yes No
 Unknown

If **YES**, C9b. Treated for TB disease Treated for LTBI
 Treated, but unknown if TB disease or LTBI

If **Treated for TB disease**,

Treatment completed **prior** to panel physician examination
 Treatment completed **after** panel physician diagnosis (DS 3030)
 At DGMQ-designated DOT site
 At non-DGMQ-designated DOT site
 Other, specify: _____

C9c. Treatment start date: ___/___/___ Start date unknown

C9d. Treatment end date: ___/___/___ End date unknown

C9e. Report of treatment administered prior to panel physician examination:

Treatment documented on overseas medical history form (DS 3026)
 Documented on DS forms & patient reported at panel physician examination
 After U.S. arrival only, patient verbally reported treatment completion
 Unknown

C9f. Standard TB treatment regimen was administered?

Standard TB treatment Non-standard TB treatment
 Unable to verify

C10a. Arrived to the U.S. on treatment?

Yes No
 Unknown

If **YES**, C10b. Treated for TB disease Treated for LTBI

C10c. Start date: ___/___/___ Start date unknown

C11a: Pre-Immigration treatment concerns?

Yes No

If **YES**, C11b. *Select all that apply:*

Treatment duration too short
 Incorrect treatment regimen
 Inadequate information provided
 Lack of adequate diagnostics
 Unknown DOT/adherence status
 Undocumented/unverified treatment
 Other, specify: _____

C12. U.S. Microscopy/Bacteriology* Sputa collected in U.S.? Yes No *Covers all results regardless of sputa collection method.

| # | Date Collected | AFB Smear | Sputum Culture | Drug Susceptibility Testing |
|---|----------------|---|--|--|
| 1 | ___/___/___ | <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown | <input type="checkbox"/> NTM <input type="checkbox"/> MTB Complex <input type="checkbox"/> Contaminated <input type="checkbox"/> Negative <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown | <input type="checkbox"/> MDR-TB <input type="checkbox"/> Mono-RIF <input type="checkbox"/> Mono-INH <input type="checkbox"/> Other DR <input type="checkbox"/> No DR <input type="checkbox"/> Not Done |
| 2 | ___/___/___ | <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown | <input type="checkbox"/> NTM <input type="checkbox"/> MTB Complex <input type="checkbox"/> Contaminated <input type="checkbox"/> Negative <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown | <input type="checkbox"/> MDR-TB <input type="checkbox"/> Mono-RIF <input type="checkbox"/> Mono-INH <input type="checkbox"/> Other DR <input type="checkbox"/> No DR <input type="checkbox"/> Not Done |
| 3 | ___/___/___ | <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown | <input type="checkbox"/> NTM <input type="checkbox"/> MTB Complex <input type="checkbox"/> Contaminated <input type="checkbox"/> Negative <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown | <input type="checkbox"/> MDR-TB <input type="checkbox"/> Mono-RIF <input type="checkbox"/> Mono-INH <input type="checkbox"/> Other DR <input type="checkbox"/> No DR <input type="checkbox"/> Not Done |

D. Evaluation Disposition in U.S.

D1a. Evaluation disposition date in U.S.: ___/___/___

D1b. State/jurisdiction of evaluation disposition in U.S.: _____

D2a. Evaluation disposition in U.S.:

Completed evaluation Initiated Evaluation / Not completed Did not initiate evaluation

D2b. *If evaluation was completed, was treatment recommended?*

Yes No

LTBI
 Active TB

D2c. *If evaluation was NOT completed, why not? Select all that apply.*

Not Located Moved within U.S., transferred to: _____ State/jurisdiction
 Lost to Follow-Up Moved outside U.S.
 Refused Evaluation Died
 Unknown 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 3 - TB, TB disease

Class 4 - TB, inactive disease

Pulmonary Extra-pulmonary Both sites

Culture-confirmed Yes No

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Alien #

D4. If diagnosed with TB disease:

State Case Number: _____
 Year State RVCT # / TBLISS #

RVCT # unknown* RVCT Reported*

TBLISS # unknown* TBLISS Reported*

City/County Case 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

E1a. U.S. treatment initiated: Yes No Unknown

E1b. If NO, specify the reason. Select all that apply:

- Patient declined against medical advice
- Lost to follow-up
- Moved within U.S., transferred to: _____
State/jurisdiction
- Died
- Moved outside the U.S.
- Prior treatment completed (year: _____)
- Currently on treatment
- Treatment not offered based on local clinic guidelines
- Unknown
- Contraindication for treatment
- Other, specify: _____

E1c. If YES: Treated for TB disease Treated for LTBI

E2. Treatment start date: ___/___/___ E3. State/jurisdiction 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 months; suspected TB disease)
- Unknown
- Other, specify: _____

E5a. U.S. treatment completion status and dates: Completed ___/___/___ Treatment ongoing
 Treatment discontinued/stopped ___/___/___ Unknown

*Completed refers to finished treatment, Treatment ongoing refers to treatment that is initiated but not yet completed. Treatment discontinued/stopped refers to initiated treatment that is not completed.

If treatment discontinued/stopped, E5b. Specify the reason. Select all that apply:

- Patient declined against medical advice
- Lost to follow-up
- Moved within U.S., transferred to: _____
State/jurisdiction
- Died
- Moved outside the U.S.
- Unknown
- Dying (treatment stopped because of imminent death, regardless of cause of death)
- Adverse effect
- Other, specify: _____
- Provider decision
- Not TB disease
- Developed TB [For patient diagnosed with LTBI]
- Pregnancy [For patient diagnosed with LTBI]

F. Evaluation Site Information

G. Treatment Site Information

Provider's Name:
 Clinic Name:
 Telephone Number:

Provider's Name:
 Clinic Name:
 Telephone Number:
 Same as evaluation site information

H. Comments
