Form approved

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**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 *Technical Instructions for Panel Physicians*:

A9. Country of examination:

A10. Country of birth:

A11a. Name in care of:

A11b. Phone number: A11c. Address:

A12a. Sponsor agency name:

A12b. Phone number: 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.?

Yes No Unknown

*If* ***YES,*** C2b. TST placement date: / /

Placement date unknown

C2c. TST mm: Unknown C2d. TST interpretation:

Positive Negative Unknown

C2e. History of Previous Positive TST:

Yes No Unknown

C3a. Was IGRA performed in the U.S.? Yes No Unknown

*If* ***YES****,* C3b. Date collected: / / Date unknown

IUs/Spots

C3c. IGRA brand:

QuantiFERON® T-SPOT Other, specify:

C3d. Result: Positive Negative Indeterminate,

Borderline, or

Invalid Unknown Equivocal

C3e. History of previous positive IGRA:

Yes No Unknown

**U.S Review of Pre-Immigration/I-693 CXR**

**U.S. Domestic CXR**

**Comparison**

C4. Pre-immigration CXR/I-693 available?

Yes No Unknown

C6a. U.S. domestic CXR done? Yes No Unknown

*If* ***YES****,* C6b. Date of U.S. CXR: / /

C8. U.S. domestic CXR comparison to pre-immigration/I-693 CXR:

Stable Worsening Improving Unknown

C5. U.S. interpretation of pre-immigration/I-693 CXR:

Normal (Negative for TB) Abnormal

Suggestive of TB Non-TB Condition

Poor Quality/Not Interpretable

Unknown

C7. Interpretation of U.S. CXR:

Normal (Negative for TB) Abnormal

Suggestive of TB Non-TB Condition

Poor Quality/Not Interpretable

Unknown

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 (0920-1238).

C9a. Completed treatment pre-immigration/I-693? 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 or civil surgeon examination Treatment completed **after** panel physician or civil surgeon 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 or civil surgeon examination:

Treatment documented on overseas medical history form (DS 3026)

Documented on DS forms & patient reported at panel physician or civil surgeon examination

After U.S. arrival only, patient verbally reported treatment completion

Unknown

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**Alien #**

**U.S. Review of Pre-Immigration/I-963 Treatment**

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/I-693 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

/ /

Positive Negative

Not Done Unknown

NTM

Contaminated Not Done

MTB Complex Negative Unknown

MDR-TB

Mono-INH No DR

Mono-RIF Other DR Not Done

2

/ /

Positive Negative

Not Done Unknown

NTM

Contaminated Not Done

MTB Complex Negative Unknown

MDR-TB

Mono-INH No DR

Mono-RIF Other DR Not Done

3

/ /

Positive Negative

Not Done Unknown

NTM MTB Complex

Contaminated Negative

Not Done Unknown

MDR-TB Mono-RIF

Mono-INH Other DR

No DR 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

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

Yes No

LTBI

Active TB

Initiated Evaluation / Not completed Did not initiate evaluation

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:

RVCT # unknown\* RVCT Reported\* Year State RVCT # / TBLISS #

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 Unknown

Contraindication for treatment local clinic guidelines 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:

Died Unknown State/ jurisdiction

Moved outside the U.S.

Dying (treatment stopped because Adverse effect Other, specify:

of imminent death, regardless of cause

of death) Not TB disease Developed TB [For

Provider decision Pregnancy [For patient patient diagnosed with

diagnosed with LTBI] 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**