Patient's Name _____ (Last) (First) (M.I.)

Street Address _____ _____ (ZIP CODE)

REPORT OF VERIFIED CASE OF TUBERCULOSIS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES-
FORM APPROVED OMB NO. 0920-0026 Exp. Date 05/31/2011

REPORT OF VERIFIED CASE OF TUBERCULOSIS

1. Date Reported

Month INV111

2. Date Submitted

Month INV177

3. Case Numbers

Year Reported (YYY INV173 cally Assigned Identification Number

State Case Number

City/County Case Number INV172

Reason:

Linking State Case Number TB207 TB208

Linking State Case Number TB209 TB210

4. Reporting Address for Case Counting

City TB080

Within City Limits *(select one)* ☐ Ye TB099

County TB081

ZIP CODE TB082

5. Count Status *(select one)*

Countable TB Case

☐ Count as a TB case

TB153

☐ ted by another U.S. area (e.g., county, state)

☐ Verified Cas initiated in a TB211 *Specify*_____

☐ Verified Case: Recurrent TB within 12 months after completion of therapy

6. Date Counted

Month TB100 ear

7. Previous Diagnosis of TB Disease *(select one)*

☐ Yes ☐ No TB102

If YES, enter year of previous TB disease diagnosis:

TB103

8. Date of Birth

M DEM115 Year

9. Sex at Birth *(select one)*

DEM114

10. Ethnicity *(select one)*

DEM155

or Latino

11. Race *(select one or more)*

DEM152

☐ Asian: *Specify*_____

☐ Black or African American

☐ Nativ DEM153 Othe *Specify*_____

☐ White

12. Country of Birth

"U.S.-born" (or born abroa DEM2003 en) *(select one)* ☐ Yes ☐

Country of birth: *Specify*_ DEM126

13. Month-Year Arrived in U.S.

Month Year

DEM2005

14. Pediatric TB Patients (<15 years old)

Country of Birth for Primary Guardian(s): *Specif* TB217

Guardian 1_____ TB218

Guardian 2_____

Patient lived outside U.S. for >2 months? *(select one)* TB215 Unknown

If YES, list countries, *specify*: _____ TB216

15. Status at TB Diagnosis *(select one)*

☐ Alive ☐ Dea TB101

Day Year

If DEAD, enter date of death: INV146

If DEAD, was TB a cause of death? *(sele*

☐ Yes TB220

16. Site of TB Disease *(select all that apply)*

☐ Pulm TB205 one and/or Joint

☐ Pleural ☐ Genitourinary

☐ Lymphatic: Cervical ☐ Meningeal

☐ Lymphatic: Intrathoracic ☐ Peritoneal

☐ Lymphatic: Axillary ☐ Other: Enter anatomic code(s) *(see list)*: 1 2 3

☐ Lymphatic: Other ☐ Site not stated

☐ Lymphatic: Unknown

☐ Laryngeal

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REPORT OF VERIFIED CASE OF TUBERCULOSIS

17. Sputum Smear *(select one)*

☐ Positi TB108
☐ Nega

Date Collected: Month TB221

18. Sputum Culture *(select one)*

☐ Positi TB109
☐ Nega

Date Collected: Month TB223

Date Result Reported: Month TB225

Reporting Laboratory Type *(select one)*: TB227 Commercial Laboratory ☐ Other

19. Smear/Pathology/Cytology of Tissue and Other Body Fluids *(select one)*

☐ Positi ☐ Not Done
☐ Neg TB110

Date Collected: Month TB228

Enter anatomic code TB111

Type of exam *(select all that apply)*: ☐ Si TB230 ogy

20. Culture of Tissue and Other Body Fluids *(select one)*

☐ Positi
☐ Negat TB113

Date Collected: Month TB231

Enter anatomic code *(see list)*: TB114

Date Result Reported: Month TB233

Reporting Laboratory Type *(select one)*: ☐ Publ Labo TB234 ☐ Other

21. Nucleic Acid Amplification Test Result *(select one)*

☐ Positi ☐ Not D
☐ Negat TB235
☐ Indeterminate

Date Collected: Month TB236

Date Result Reported: Month TB240

Enter specimen type: TB238
OR
If not Sputum, enter anatomic code *(see list)*: TB239

Reporting Laboratory Type *(select one)*:
☐ Public He Laborato TB242 ☐ Other

Initial Chest Radiograph and Other Chest Imaging Study

22A. Initial Chest Radiograph *(select one)*

☐ Normal ☐ Abnorm TB116 ☐ Not Done ☐ Unknown

* For ABNORMAL Initial Chest Radiograph: Evidence of a cavity *(select one)*: ☐ Yes TB243 nown

Evidence of miliary TB *(select one)*: ☐ Ye TB244 nown

22B. Initial Chest CT Scan or Other Chest Imaging Study *(select one)*

☐ Normal ☐ Abnorm TB245 ☐ Not Done ☐ Unknown

* For ABNORMAL Initial Chest Radiograph: Evidence of a cavity *(select one)*: ☐ Yes TB246 nown

Evidence of miliary TB *(select one)*: ☐ Ye TB247 nown

23. Tuberculin (Mantoux) Skin Test at Diagnosis *(select one)*

☐ Pos TB119
☐ Negative ☐ Unknown

Date Tuberculin Skin Test (TST) Placed: Month TB248

Millimeters (mm) of induration: TB120

24. Interferon Gamma Release Assay for *Mycobacterium tuberculosis* at Diagnosis *(select one)*

☐ Posi TB250
☐ Negative ☐ Unknown
☐ Indeterminate

Date Collected: Month TB251

Test type:
Specify TB253

25. Primary Reason Evaluated for TB Disease *(select one)*

☐ TB S TB254
☐ Abn onsistent with TB)
☐ Contact Investigation
☐ Targeted Testing
☐ Health Care Worker
☐ Employment/Administrative Testing
☐ Immigration Medical Exam
☐ Incidental Lab Result
☐ Unknown

REPORT OF VERIFIED CASE OF TUBERCULOSIS

26. HIV Status at Time of Diagnosis *(select one)*

☐ Negative ☐ Not Offered ☐ Unknown
☐ Positive ☐ Test Done, Results Unknown

TB122

If POSITIVE, enter:
State HIV/AIDS Patient Number: ☐☐☐☐☐☐☐☐☐☐ City/County HIV/AIDS Patient Number: ☐☐☐☐☐☐☐☐☐☐

TB125 TB126

27. Homeless Within Past Year *(select one)*

☐ ☐ Unknown

TB127

28. Resident of Correctional Facility at Time of Diagnosis *(select one)* ☐ No ☐ Unknown

If YES, *(select one)*:
☐ Federal Prison ☐ Other Correctional Facility
☐ State Prison ☐ Juvenile Correction Facility ☐ Unknown

If YES, under custody of Immigration and Customs Enforcement? *(select one)*
☐ No

TB128 TB129 TB256

29. Resident of Long-Term Care Facility at Time of Diagnosis *(select one)* ☐ No ☐ Unknown

If YES, *(select one)*:
☐ Nursing Home ☐ Residential ☐ Alcohol or Drug Treatment Facility ☐ Unknown
☐ Hospital-Based Facility ☐ Mental Health Residential Facility ☐ Other Long-Term Care Facility

TB130 TB131

30. Primary Occupation Within the Past Year *(select one)*

☐ Health Care Worker ☐ Military ☐ Retired ☐ Not Seeking Employment (e.g. student, homemaker, disabled person)
☐ Correctional Facility Employee ☐ Other Occupation ☐ Unemployed ☐ Unknown

TB206

31. Injecting Drug Use Within Past Year *(select one)* ☐ ☐ Unknown

TB148

32. Non-Injecting Drug Use Within Past Year *(select one)* ☐ ☐ Unknown

TB149

33. Excess Alcohol Use Within Past Year *(select one)* ☐ ☐ Unknown

TB150

34. Additional TB Risk Factors *(select all that apply)*

☐ Contact of MDR-TB Patient (Suspected or Confirmed) ☐ Incomplete TB Therapy ☐ Diabetes Mellitus ☐ Other *Specify* _____
☐ Contact of Infectious TB Patient ☐ Immunosuppressive Therapy ☐ End-Stage Renal Disease ☐ None
☐ Missed Contact (2 years or less) ☐ Post-organ Transplantation ☐ Immunosuppression (not HIV/AIDS)

TB257 TB258

35. Immigration Status at First Entry to the U.S. *(select one)*

☐ Not Applicable ☐ Student Visa ☐ Tourist Visa ☐ Asylee or Parolee
- "U.S.-born" (or born abroad to a parent who was ☐ Work Visa ☐ Family/Fiancé Visa ☐ Other Immigration Status
- Born in 1 of the U.S. Territories, U.S. Island Areas, or U.S. Outlying Areas ☐ Employment Visa ☐ Refugee ☐ Unknown

TB259

36. Date Therapy Started

Month Day Year
☐☐ ☐☐ ☐☐☐☐

TB147

37. Initial Drug Regimen *(select one option for each drug)*

Isoniazid	TB132	Ethionamide	TB137	Moxifloxacin	TB262
Rifampin	TB133	Amikacin	TB142	Cycloserine	TB139
Pyrazinamide	TB134	Kanamycin	TB138	Para-Amino Salicylic Acid	TB141
Ethambutol	TB135	Capreomycin	TB140	Other	TB146
Streptomycin	TB136	Ciprofloxacin	TB144	*Specify* _____	TB263
Rifabutin	TB143	Levofloxacin	TB261	Other	TB264
Rifapentine	TB260	Ofloxacin	TB145	*Specify* _____	TB265

Comments:

_____
_____
_____
_____

Patient's Name _____
(Last) (First) (M.I.)

Street Address _____ _____
(Number, Street, City, State) (ZIP CODE)

REPORT OF VERIFIED CASE OF TUBERCULOSIS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL
AND PREVENTION (CDC)
ATLANTA, GEORGIA 30333
FORM APPROVED OMB NO. 0920-0026 Exp. Date 05/31/2011

REPORT OF VERIFIED CASE OF TUBERCULOSIS

Initial Drug Susceptibility Report

(Follow Up Report – 1)

Year Counted Year(TB100)

State Case Number INV173

City/County Case Number INV172

Submit this report for all culture-positive cases.

38. Genotyping Accession Number

Isolate submitted for genotyping *(select one)*: ☐ No ☐ Yes TB266

If YES, genotyping accession number for episode: TB267

39. Initial Drug Susceptibility Testing

Was drug susceptibility testing done? *(select one)* ☐ No TB156

If NO or UNKNOWN, do not complete the rest of Follow Up Report –1

If YES, enter date FIRST isolate collected for which drug susceptibility testing was done:

Month Day Year TB157

Enter specimen type: ☐ Sputum TB268

OR

If not Sputum, enter anatomic code *(see* TB269

40. Initial Drug Susceptibility Results *(select one option for each drug)*

	Resistant	Susceptible	Not Done	Unknown
Isoniazid	TB158		☐	☐
Rifampin	TB159		☐	☐
Pyrazinamide	TB160		☐	☐
Ethambutol	TB161		☐	☐
Streptomycin	TB162		☐	☐
Rifabutin	TB169		☐	☐
Rifapentine	TB270		☐	☐
Ethionamide	TB163		☐	☐
Amikacin	TB168		☐	☐
Kanamycin	TB164		☐	☐

	Resistant	Susceptible	Not Done	Unknown
Capreomycin	TB166		☐	☐
Ciprofloxacin	TB170		☐	☐
Levofloxacin	TB271		☐	☐
Ofloxacin	TB171		☐	☐
Moxifloxacin	TB272		☐	☐
Other Quinolones	TB273		☐	☐
Cycloserine	TB165		☐	☐
Para-Amino Salicylic Acid	TB167		☐	☐
Other	TB172		☐	☐
Specify _____	TB274			
Other	TB275		☐	☐
Specify _____	TB276			

Comments:

_____

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Patient's Name _____
(Last) (First) (M.I.)

Street Address _____ _____
(Number, Street, City, State) (ZIP CODE)

REPORT OF VERIFIED CASE OF TUBERCULOSIS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL
AND PREVENTION (CDC)
ATLANTA, GEORGIA 30333
FORM APPROVED OMB NO. 0920-0026 Exp. Date 05/31/2011

REPORT OF VERIFIED CASE OF TUBERCULOSIS

Case Completion Report

(Follow Up Report – 2)

Year Counted Year(TB100)

State Case Number INV173

City/County Case Number INV172

Submit this report for all cases in which the patient was alive at diagnosis.

41. Sputum Culture Conversion Documented *(select one)* ☐ No TB173

If YES, enter date specimen collected for FIRST consistently negative sputum culture:

Month Day Year TB175

If NO, enter reason for not documenting sputum culture conversion *(select one)*:

☐ No Follow-up Sputum Des TB277 ☐ Patient Refused ☐ Patient Lost to Follow-Up

☐ No Follow-up ☐ Other *Specify* _____ TB278 _____

☐ Died ☐ Unknown

42. Moved

Did the patient move during TB therapy? *(select one)* TB279

If YES, moved to where *(select all that apply)*:

☐ In state, (City) TB282 *r city/county) Specify* _____ *Specify* (County) TB284

☐ Out of sta TB280 *Specify* TB286 _____ *Specify* _____

☐ Out of the *Specify* TB288 _____ *Specify* _____

If moved out of the U.S., transnational referral? *(select one)* TB281

43. Date Therapy Stopped

Month Day Year TB176

44. Reason Therapy Stopped or Never Started *(select one)*

☐ Completed Therapy ☐ Not TB

☐ Lost TB177 ied

☐ Uncooperative or Refused ☐ Other

☐ Adverse Treatment Event ☐ Unknown

If DIED, indicate cause of death *(select one)*:

☐ Related to TB d TB290 B disease

☐ Related to TB t

45. Reason Therapy Extended >12 months *(select all that apply)*

☐ Rifampin Resist TB291 ☐ Non-adherence ☐ Clinically Indicated – other reasons

☐ Adverse Drug R ☐ Failure ☐ Other *Specify* _____ TB292 _____

46. Type of Outpatient Health Care Provider *(select all that apply)*

☐ Local/State He TB178 ☐ IHS, Tribal HD, or Tribal Corporation ☐ Inpatient Care Only ☐ Unknown

☐ Private Outpati ☐ Institutional/Correctional ☐ Other

Comments:

_____

_____

_____

_____

_____

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Patient's Name _____ (Last) (First) (M.I.) State Case No. _____

REPORT OF VERIFIED CASE OF TUBERCULOSIS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL
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Case Completion Report - *Continued*

(Follow Up Report – 2)

47. Directly Observed Therapy (DOT) *(select one)*

- ☐ No, Totally Self-Administered
- ☐ Yes, TB179 ed
- ☐ Yes, Both Directly Observed and Self-Administered
- ☐ Unknown

Number of weeks of directly observed therapy (DOT) ☐ TB181

48. Final Drug Susceptibility Testing

Was follow-up drug susceptibility testing done? *(select one)* ☐ No ☐ Yes ☐ Unknow TB182

If NO or UNKNOWN, do not complete the rest of Follow Up Report –2

If YES, enter date FINAL isolate collected for which drug susceptibility testing was done:

Month Day Year

TB183

Enter specimen type: ☐ Sputum TB293

OR

If not Sputum, enter anatomic code *(see* TB294

49. Final Drug Susceptibility Results *(select one option for each drug)*

	Resistant	Susceptible	Not Done	Unknown
Isoniazid	TB184		☐	☐
Rifampin	TB185		☐	☐
Pyrazinamide	TB186		☐	☐
Ethambutol	TB187		☐	☐
Streptomycin	TB188		☐	☐
Rifabutin	TB195		☐	☐
Rifapentine	TB295		☐	☐
Ethionamide	TB189		☐	☐
Amikacin	TB194		☐	☐
Kanamycin	TB190		☐	☐

	Resistant	Susceptible	Not Done	Unknown
Capreomycin	TB192		☐	☐
Ciprofloxacin	TB196		☐	☐
Levofloxacin	TB296		☐	☐
Ofloxacin	TB197		☐	☐
Moxifloxacin	TB297		☐	☐
Other Quinolones	TB298		☐	☐
Cycloserine	TB191		☐	☐
Para-Amino Salicylic Acid	TB193		☐	☐
Other	TB198		☐	☐
Specify _____	TB299			
Other	TB300		☐	☐
Specify _____	TB301			

Comments:

_____

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