



**REPORT OF VERIFIED CASE OF TUBERCULOSIS**

**17. Sputum Smear (select one)** Date Collected: \_\_\_\_\_  
 Positive  Not Done  
 Negative  Unknown

**18. Sputum Culture (select one)** Date Collected: \_\_\_\_\_ Date Result Reported: \_\_\_\_\_  
 Positive  Not Done  
 Negative  Unknown  
 Reporting Laboratory Type (select one):  Public Health Laboratory  Commercial Laboratory  Other

**19. Smear/Pathology/Cytology of Tissue and Other Body Fluids (select one)** Date Collected: \_\_\_\_\_ Enter anatomic code (see list): \_\_\_\_\_ Type of exam (select all that apply):  Smear  Pathology/Cytology  
 Positive  Not Done  
 Negative  Unknown

**20. Culture of Tissue and Other Body Fluids (select one)** Date Collected: \_\_\_\_\_ Enter anatomic code (see list): \_\_\_\_\_ Date Result Reported: \_\_\_\_\_  
 Positive  Not Done  
 Negative  Unknown  
 Reporting Laboratory Type (select one):  Public Health Laboratory  Commercial Laboratory  Other

**21. Nucleic Acid Amplification Test Result (select one)** Date Collected: \_\_\_\_\_ Date Result Reported: \_\_\_\_\_  
 Positive  Not Done  
 Negative  Unknown  
 Indeterminate  
 Enter specimen type:  Sputum OR If not Sputum, enter anatomic code (see list): \_\_\_\_\_  
 Reporting Laboratory Type (select one):  Public Health Laboratory  Commercial Laboratory  Other

**Initial Chest Radiograph and Other Chest Imaging Study**

**22A. Initial Chest Radiograph (select one)**  Normal  Abnormal\* (consistent with TB)  Not Done  Unknown  
 \* For ABNORMAL Initial Chest Radiograph: Evidence of a cavity (select one):  Yes  No  Unknown  
 Evidence of miliary TB (select one):  Yes  No  Unknown

**22B. Initial Chest CT Scan or Other Chest Imaging Study (select one)**  Normal  Abnormal\* (consistent with TB)  Not Done  Unknown  
 \* For ABNORMAL Initial Chest Radiograph: Evidence of a cavity (select one):  Yes  No  Unknown  
 Evidence of miliary TB (select one):  Yes  No  Unknown

**23. Tuberculin (Mantoux) Skin Test at Diagnosis (select one)** Date Tuberculin Skin Test (TST) Placed: \_\_\_\_\_ Millimeters (mm) of induration: \_\_\_\_\_  
 Positive  Not Done  
 Negative  Unknown

**24. Interferon Gamma Release Assay for Mycobacterium tuberculosis at Diagnosis (select one)** Date Collected: \_\_\_\_\_  
 Positive  Not Done  
 Negative  Unknown  
 Indeterminate  
 Test type: Specify \_\_\_\_\_

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

- TB Symptoms
- Abnormal Chest Radiograph (consistent with TB)
- Contact Investigation
- Targeted Testing
- Health Care Worker
- Employment/Administrative Testing
- Immigration Medical Exam
- Incidental Lab Result
- Unknown

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

- Negative     Indeterminate     Not Offered     Unknown  
 Positive     Refused     Test Done, Results Unknown

If POSITIVE, enter:

State HIV/AIDS Patient Number:

City/County HIV/AIDS Patient Number:

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

- No     Yes     Unknown

**28. Resident of Correctional Facility at Time of Diagnosis** (select one)

- No     Yes     Unknown

If YES, (select one):

- Federal Prison     Local Jail     Other Correctional Facility  
 State Prison     Juvenile Correction Facility     Unknown

If YES, under custody of Immigration and Customs Enforcement? (select one)

- No     Yes

**29. Resident of Long-Term Care Facility at Time of Diagnosis** (select one)

- No     Yes     Unknown

If YES, (select one):

- Nursing Home     Residential Facility     Alcohol or Drug Treatment Facility     Unknown  
 Hospital-Based Facility     Mental Health Residential Facility     Other Long-Term Care Facility

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

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

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

- No     Yes     Unknown

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

- No     Yes     Unknown

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

- No     Yes     Unknown

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

- Contact of MDR-TB Patient (2 years or less)     Incomplete LTBI Therapy     Diabetes Mellitus     Other Specify \_\_\_\_\_  
 Contact of Infectious TB Patient (2 years or less)     TNF- $\alpha$  Antagonist Therapy     End-Stage Renal Disease     None  
 Missed Contact (2 years or less)     Post-organ Transplantation     Immunosuppression (not HIV/AIDS)

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

- Not Applicable     Immigrant Visa     Tourist Visa     Asylee or Parolee  
 "U.S.-born" (or born abroad to a parent who was a U.S. citizen)     Student 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

**36. Date Therapy Started**

Month:      Day:      Year:

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

	No	Yes	Unk		No	Yes	Unk		No	Yes	Unk
Isoniazid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ethionamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Moxifloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifampin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amikacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cycloserine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pyrazinamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kanamycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Para-Amino Salicylic Acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethambutol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Capreomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Streptomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____			
Rifabutin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Levofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifapentine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____			

**Comments:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_





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

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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

**Case Completion Report - Continued**

**(Follow Up Report - 2)**

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

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

Number of weeks of directly observed therapy (DOT)

**48. Final Drug Susceptibility Testing**

Was follow-up drug susceptibility testing done? (select one)  No  Yes  Unknown

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:

Enter specimen type:  Sputum

**OR**

If not Sputum, enter anatomic code (see list):

Month   Day   Year

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

	Resistant	Susceptible	Not Done	Unknown		Resistant	Susceptible	Not Done	Unknown
Isoniazid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Capreomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifampin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pyrazinamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Levofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethambutol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Streptomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Moxifloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifabutin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Quinolones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifapentine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cycloserine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethionamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Para-Amino Salicylic Acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amikacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kanamycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____				
					Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Specify _____				

**Comments:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
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