Data Collection Form—Final

**TB Latent Infection Surveillance System (TBLISS) – Cleared 10/16/2019**

# Administrative Information

1. **Date Reported:** 🞏🞏/🞏🞏/🞏🞏🞏🞏
2. **Date Counted**
   1. MMWR Week: 🞏🞏
   2. MMWR Year: 🞏🞏🞏🞏
3. **State Case Number:**🞏🞏🞏🞏- 🞏🞏- 🞏🞏🞏🞏🞏🞏🞏🞏🞏
4. **Local Case Number:** 🞏🞏🞏🞏- 🞏🞏- 🞏🞏🞏🞏🞏🞏🞏🞏🞏
5. **Case Already Counted by Another Reporting Area?**

\_\_\_ Yes, another U.S. reporting area (State case number from other area:  
 🞏🞏🞏🞏- 🞏🞏- 🞏🞏🞏🞏🞏🞏🞏🞏🞏)

\_\_\_ Yes, another country (Specify country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_ No

# Demographics and Initial Evaluation

1. **Reporting Address**
   1. City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. Is the Patient’s Residence within City Limits?

\_\_\_ Yes

\_\_\_ No

\_\_\_ Unknown

* 1. County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  2. ZIP Code: 🞏🞏🞏🞏🞏-🞏🞏🞏🞏
  3. Census Tract (11-digit GEOID): 🞏🞏🞏🞏🞏🞏🞏🞏🞏🞏🞏

1. **Date of Birth**: 🞏🞏/🞏🞏/🞏🞏🞏🞏
2. **Sex at Birth**

\_\_\_ Male

\_\_\_ Female

If Female, Was Patient Pregnant at Time of Diagnostic Evaluation?

\_\_\_ Yes

\_\_\_ No

\_\_\_ Unknown

\_\_\_ Unknown

1. **Ethnicity**

\_\_\_ Hispanic or Latino

\_\_\_ Not Hispanic or Latino

\_\_\_ Unknown

1. **Race**

\_\_\_ American Indian or Alaska Native

\_\_\_ Asian (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_ Black or African American

\_\_\_ Native Hawaiian or Other Pacific Islander (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_ White

\_\_\_ Other Race (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_ Unknown

1. **Nativity**
   1. Country of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If NOT United States, Date of First U.S. Arrival: 🞏🞏/🞏🞏/🞏🞏🞏🞏)

* 1. Eligible for U.S. Citizenship/Nationality at Birth (regardless of country of birth)?

\_\_\_ Yes

\_\_\_ No

\_\_\_ Unknown

* 1. Countries of Birth for Primary Guardian(s) (pediatric [<15 years old] cases only)
     1. Guardian 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
     2. Guardian 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Country of Usual Residence**
   1. Country of Usual Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. If **NOT** U.S. Reporting Area, Has Been in United States for ≥90 days (inclusive of Report Date)?

\_\_\_ Yes

\_\_\_ No

\_\_\_ Unknown

1. **Initial Reason Evaluated for TB**

\_\_\_ Contact Investigation

\_\_\_ Screening

\_\_\_ TB Symptoms

\_\_\_ Other

\_\_\_ Unknown

# Risk Factors

1. **Occupation and Industry**
2. Has the patient *ever* worked as one of the following? (select all that apply)

\_\_\_ Healthcare Worker

\_\_\_ Correctional Facility Employee

\_\_\_ Migrant/Seasonal Worker

\_\_\_ None of the above

\_\_\_ Unknown

1. Patient’s Current Occupation(s) and Industry(ies)

|  |  |
| --- | --- |
| Occupation | Industry |
|  |  |
|  |  |
|  |  |

1. **Other Risk Factors**

|  |  |
| --- | --- |
| Risk Factor | Indicator |
| Diabetic at Diagnostic Evaluation | \_\_\_Yes \_\_\_No \_\_\_ Unknown |
| Homeless in the Past 12 Months | \_\_\_Yes \_\_\_No \_\_\_ Unknown |
| Homeless Ever | \_\_\_Yes \_\_\_No \_\_\_ Unknown |
| Resident of Correctional Facility at Diagnostic Evaluation | \_\_\_Yes \_\_\_No \_\_\_ Unknown |
| Resident of Correctional Facility Ever | \_\_\_Yes \_\_\_No \_\_\_ Unknown |
| Resident of Long-Term Care Facility at Diagnostic Evaluation | \_\_\_Yes \_\_\_No \_\_\_ Unknown |
| Injecting Drug Use in the Past 12 Months | \_\_\_Yes \_\_\_No \_\_\_ Unknown |
| Noninjecting Drug Use in the Past 12 Months | \_\_\_Yes \_\_\_No \_\_\_ Unknown |
| Heavy Alcohol Use in the Past 12 Months | \_\_\_Yes \_\_\_No \_\_\_ Unknown |
| TNF-α Antagonist Therapy | \_\_\_Yes \_\_\_No \_\_\_ Unknown |
| Post-Organ Transplantation | \_\_\_Yes \_\_\_No \_\_\_ Unknown |
| End Stage Renal Disease | \_\_\_Yes \_\_\_No \_\_\_ Unknown |
| Viral Hepatitis (B or C only) | \_\_\_Yes \_\_\_No \_\_\_ Unknown |
| Other Immunocompromise (other than HIV/AIDS) | \_\_\_Yes \_\_\_No \_\_\_ Unknown |
| Other (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | \_\_\_Yes \_\_\_No \_\_\_ Unknown |

1. **If Resident of Correctional Facility at Diagnostic Evaluation, Type of Facility?**

\_\_\_ Federal Prison

\_\_\_ State Prison

\_\_\_ Local Jail

\_\_\_ Juvenile Correction Facility

\_\_\_ Other Correctional Facility

\_\_\_ Unknown

1. **If Resident of Long-Term Care Facility at Diagnostic Evaluation, Type of Facility?**

\_\_\_Nursing Home

\_\_\_Hospital-Based Facility

\_\_\_Residential Facility

\_\_\_Mental Health Residential Facility

\_\_\_Alcohol or Drug Treatment Facility

\_\_\_Other Long-Term Care Facility

\_\_\_Unknown

1. **Current Smoking Status at Diagnostic Evaluation**

\_\_\_ Current everyday smoker

\_\_\_ Current someday smoker

\_\_\_ Former smoker

\_\_\_ Never smoker

\_\_\_ Smoker, current status unknown

\_\_\_ Unknown if ever smoked

1. **Lived outside of the United States for >2 months (uninterrupted)?**

\_\_\_Yes

\_\_\_No

\_\_\_Unknown

# Diagnostic Testing (Non-DST)

1. **Tuberculin Skin Test and All Non-DST TB Laboratory Test Results**

*Please provide a response for each of the main test types (culture, smear, pathology/cytology, NAA, TST, IGRA, HIV, diabetes) If test was not done please indicate so. See list example in table.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Test Type | Specimen Source Site | Date Collected/Placed | Date Reported/Read | Test Result (Qual.) | Test Result (Quant.) | Test Result (Units of Measure) |
| TST | Skin Structure | 🞏🞏/🞏🞏/🞏🞏🞏🞏 | 🞏🞏/🞏🞏/🞏🞏🞏🞏 | Positive | 15 | mm |
| IGRA [spec. type] | Blood | 🞏🞏/🞏🞏/🞏🞏🞏🞏 | 🞏🞏/🞏🞏/🞏🞏🞏🞏 |  |  |  |
|  |  |  |  |  |  |  |

**Test Type Options:** Smear, Pathology, Cytology, NAA, Culture, TST, IGRA-QFT, IGRA-TSpot, IGRA-Unknown, IGRA-Other, HIV, CD4 Count, Hemoglobin A1c, Fasting Blood Glucose, Other Test Type, and Pathology/Cytology

**Specimen Source Options:** Examples: Skin Structure, Blood, Sputum

**Test Result (Qualitative) Options:** Positive, Negative, Indeterminate, Not Done, Unknown, Refused, Test Done Result Unknown

**Test Result (Units of Measure) Options:** Examples: Millimeters of Induration (TST), Cell Count (CD4), Percentage (HGB-A1c), Milligrams per deciliter (FBG)

1. **Chest Radiograph or Other Chest Imaging Study Results**

(Please provide a response for each of the main test types (plain chest radiograph, chest CT Scan) and if test was not done please indicate so. *See list example in table.*)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Study Type | Date of Study | Result | Cavity? | Miliary? |
| Plain Chest X-Ray | 🞏🞏/🞏🞏/🞏🞏🞏🞏 |  |  |  |
| CT Scan | 🞏🞏/🞏🞏/🞏🞏🞏🞏 |  |  |  |
|  |  |  |  |  |

**Study Type Options:** Plain Chest X-Ray, CT Scan, MRI, PET, Other

**Result Options:** Not Consistent with TB, Consistent with TB, Not Done, Unknown

**Cavity Options**: Yes, No, Unknown

**Miliary Options**: Yes, No, Unknown

# Epidemiologic Investigation

1. **Case Meets Binational Reporting Criteria?**

\_\_\_ Yes

If Yes, Which Criteria were Met? (Select All That Apply)

\_\_\_ Exposure to Suspected Product from Canada or Mexico (e.g., dairy product for *M. bovis* case)

\_\_\_ Has Case Contacts in or From Mexico or Canada

\_\_\_ Potentially Exposed by a Resident of Mexico or Canada

\_\_\_ Potentially Exposed while in Mexico or Canada

\_\_\_ Resident of Canada or Mexico

\_\_\_ Other Situations that May Require Binational Notification or Coordination of Response

\_\_\_ No

\_\_\_ Unknown

1. **Case Identified During the Contact Investigation Around Another Case?**

\_\_\_ Yes

If Yes, Evaluated for TB During that Contact Investigation?

\_\_\_ Yes

\_\_\_ No

\_\_\_ Unknown

\_\_\_ No

\_\_\_ Unknown

1. **Complete Table Below for All Known TB and LTBI Cases Epidemiologically Linked to this Case**(an unlimited number of rows may be entered):

|  |
| --- |
| State Case Number |
| 🞏🞏🞏🞏- 🞏🞏- 🞏🞏🞏🞏🞏🞏🞏🞏🞏 |
| 🞏🞏🞏🞏- 🞏🞏- 🞏🞏🞏🞏🞏🞏🞏🞏🞏 |
| 🞏🞏🞏🞏- 🞏🞏- 🞏🞏🞏🞏🞏🞏🞏🞏🞏 |

# Treatment and Outcome Information

1. **LTBI Therapy Started**?

\_\_\_ Yes (Treatment Start Date: 🞏🞏/🞏🞏/🞏🞏🞏🞏)

Specify Initial LTBI Regimen:

\_\_\_ Isoniazid (9 months; 9H)

\_\_\_ Isoniazid (6 months; 6H)

\_\_\_ Isoniazid/Rifapentine (3 months; 3HP)

\_\_\_ Rifampin (4 months; 4R)

\_\_\_ RIPE/HRZE (2 months)

\_\_\_ Other (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_ No

Why Not?

\_\_\_ Lost to follow-up

\_\_\_ History of previous treatment for TB or LTBI

\_\_\_ Treatment medically contraindicated

\_\_\_ Treatment not offered based on local clinic guidelines

\_\_\_ Provider decision (not based on local clinic guidelines)

\_\_\_ Drug shortage

\_\_\_ Patient refused

\_\_\_ Other (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_ Unknown

If Therapy Not Started or Unknown, STOP HERE.  
If Therapy was Started, Continue to Question 26

1. **Date Therapy Stopped:** 🞏🞏/🞏🞏/🞏🞏🞏🞏
2. **Treatment Administration** (select all that apply)

\_\_\_ DOT (Directly Observed Therapy, in person)

\_\_\_ EDOT (Electronic DOT, via video call or other electronic method)

\_\_\_ Self-Administered

1. **Reason LTBI Therapy Stopped?**

\_\_\_ Completed Treatment

\_\_\_ Lost to Follow-up

\_\_\_ Patient Choice

\_\_\_ Pregnancy

\_\_\_ Not LTBI (Clinician Decision)

\_\_\_ Other (Specify: \_\_\_\_\_\_\_\_\_\_\_)

\_\_\_ Developed TB (NTSS State Case Number:  
🞏🞏🞏🞏- 🞏🞏- 🞏🞏🞏🞏🞏🞏🞏🞏🞏)

\_\_\_ Severe Adverse Event (select all that apply)

\_\_\_ Hospitalized

\_\_\_ Died

***(PLEASE IMMEDIATELY REPORT ALL ADVERSE EVENTS RESULTING IN HOSPITALIZATION OR DEATH TO CDC AT*** [***LTBIDRUGEVENTS@CDC.GOV***](mailto:LTBIDRUGEVENTS@CDC.GOV)***)***

**END OF TBLISS Data Collection Form**