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… …cally Assigned Identification Number

State Case Number INV173

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 …ear TB100

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)*

…or Latino DEM155

11. Race *(select one or more)* DEM152

Asian. *Specify*_____

Black or African American

Nativ… Othe… DEM153 *Specify*_____

White

12. Country of Birth

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

Country of birth: *Specify*_ DEM2003 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

If DEAD, enter date of death: Day Year INV146

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

Yes TB220

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

Pulm… TB205 …ne and/or Joint

Pleural … Genitourinary

Lymphatic: Cervical

Lymphatic: Intrathoracic

Lymphatic: Axillary

Lymphatic: Other

Lymphatic: Unknown

Laryngeal

Meningeal

Peritoneal

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

Site not stated

Public reporting burden of this collection of information is estimated to average 35 minutes per response, 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, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0026). Do not send the completed form to this address.

Information contained on this form which would permit identification of any individual has been collected with a guarantee that it will be held in strict confidence, will be used only for surveillance purposes, and will not be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 U.S.C. 242m).

REPORT OF VERIFIED CASE OF TUBERCULOSIS

17. Sputum Smear *(select one)*

☐ Positive ☐ Negative **TB108**

Date Collected: Month Year **TB221**

18. Sputum Culture *(select one)*

☐ Positive ☐ Negative **TB109**

Date Collected: Month Year **TB223**

Date Result Reported: Month Year **TB225**

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

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

☐ Positive ☐ Not Done ☐ Negative **TB110**

Date Collected: Month Year **TB228**

Enter anatomic code **TB111**

Type of exam *(select all that apply)*: ☐ Smear ☐ Pathology **TB230**

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

☐ Positive ☐ Negative **TB113**

Date Collected: Month Day Year **TB231**

Enter anatomic code *(see list)*: **TB114**

Date Result Reported: Month **TB233**

Reporting Laboratory Type *(select one)*: ☐ Public Health Laboratory **TB234** ☐ Other

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

☐ Positive ☐ Negative ☐ Indeterminate **TB235**

Date Collected: Month Year **TB236**

Date Result Reported: Month Year **TB240**

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

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

Initial Chest Radiograph and Other Chest Imaging Study

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

☐ Normal ☐ Abnormal **TB116** ☐ Not Done ☐ Unknown

* For ABNORMAL Initial Chest Radiograph: Evidence of a cavity *(select one)*: ☐ Yes ☐ No ☐ Unknown **TB243**

Evidence of miliary TB *(select one)*: ☐ Yes ☐ No ☐ Unknown **TB244**

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

☐ Normal ☐ Abnormal **TB245** ☐ Not Done ☐ Unknown

* For ABNORMAL Initial Chest Radiograph: Evidence of a cavity *(select one)*: ☐ Yes ☐ No ☐ Unknown **TB246**

Evidence of miliary TB *(select one)*: ☐ Yes ☐ No ☐ Unknown **TB247**

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

☐ Positive ☐ Negative ☐ Unknown **TB119**

Date Tuberculin Skin Test (TST) Placed: Month Year **TB248**

Millimeters (mm) of induration: **TB120**

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

☐ Positive ☐ Negative ☐ Unknown ☐ Indeterminate **TB250**

Date Collected: Month Year **TB251**

Test type: *Specify* **TB253**

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

☐ TB Symptoms **TB254**
☐ Abnormal Chest Radiograph (consistent 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 ☐ Positive **TB122** ☐ Not Offered ☐ Test Done, Results Unknown ☐ Unknown

If POSITIVE, enter:

State HIV/AIDS Patient Number: **TB125**

City/County HIV/AIDS Patient Number: **TB126**

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

TB127 ☐ Unknown

28. Resident of Correctional Facility at Time of Diagnosis *(select one)* ☐ No **TB128** ☐ Unknown

If YES, *(select one)*:

☐ Federal Prison **TB129** ☐ Other Correctional Facility

☐ State Prison ☐ Juvenile Correction Facility ☐ Unknown

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

☐ No **TB256**

29. Resident of Long-Term Care Facility at Time of Diagnosis *(select one)* ☐ No **TB130** ☐ Unknown

If YES, *(select one)*:

☐ Nursing Home ☐ Reside **TB131** ☐ 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 ☐ Mi **TB206** etired ☐ 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)*

TB148 ☐ Unknown

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

TB149 ☐ Unknown

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

TB150 ☐ Unknown

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

☐ Contact of MDR-TB Patient (S ☐ TB Therapy ☐ Diabetes Mellitus ☐ Other *Specify* **TB258**

☐ Contact of Infectious TB Pati **TB257** 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 ☐ ant Visa ☐ Tourist Visa ☐ Asylee or Parolee

- "U.S.-born" (or born abroad to a parent who was **TB259** t 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

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:

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, out of jurisdiction *(enter city/county)* *Specify* (City) TB282 *Specify* (County) TB284

☐ Out of state TB280 *Specify* TB286 *Specify*

☐ Out of the U.S. *(enter country)* *Specify* TB288 *Specify*

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

43. Date Therapy Stopped

Month Day Year

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

☐ Completed Therapy ☐ Not TB

☐ Lost TB177 ☐ Died

☐ 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 ☐ IHS, Tribal HD, or Tribal Corporation ☐ Inpatient Care Only ☐ Unknown

☐ Private Outpati TB178 ☐ Institutional/Correctional ☐ Other

Comments:

Public reporting burden of this collection of information is estimated to average 35 minutes per response, 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, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0026). Do not send the completed form to this address.

Information contained on this form which would permit identification of any individual has been collected with a guarantee that it will be held in strict confidence, will be used only for surveillance purposes, and will not be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 U.S.C. 242m).

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

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 - *Continued*

(Follow Up Report – 2)

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

- ☐ No, Totally Self-Administered
- ☐ Yes, TB179
- ☐ 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: