

Tuberculosis Disease

Local Health Department _____

REPORT AND DATE (sent to State)

Initial ____/____/____

Verification ____/____/____

Closure ____/____/____

Case Manager _____

Treating Physician(s) _____

Phone _____

CASE IDENTIFICATION

Last Name _____ First Name _____ MI _____

Phone(s) _____

Address _____
street city zip

Name of institution, if applicable (e.g. correctional facility, homeless shelter, nursing home) _____

SOURCES OF REPORT

Lab Infection control
 Physician _____

Name _____

Reported to LHD on ____/____/____
date of first report

Reported at death? Yes No

DEMOGRAPHICS

SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH ____/____/____	RACE (self-identified; select all that apply) <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black <input type="checkbox"/> Asian _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Hawaiian/Pac Islander _____ <input type="checkbox"/> Latin American Indigenous _____	HISPANIC <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	COUNTRY OF BIRTH <input type="checkbox"/> US <input type="checkbox"/> US Territory _____ <input type="checkbox"/> Other _____ Date of entry to US ____/____/____
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IMMIGRATION STATUS	At entry	Current	FOR PEDIATRIC TB (age <15) Lived outside US >2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, where: _____ Countries of birth of guardians: _____ _____	PRIMARY OCCUPATION IN LAST 12 MONTHS <input type="checkbox"/> Health care worker <input type="checkbox"/> Other employment _____ <input type="checkbox"/> Correctional worker <input type="checkbox"/> Unemployed <input type="checkbox"/> Migrant worker <input type="checkbox"/> Retired <input type="checkbox"/> Not seeking employment (eg student, disabled, homemaker) If not seeking, reason: _____ Worksite: _____
US born/NA	<input type="checkbox"/>	<input type="checkbox"/>		HEALTH INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No
Immigrant visa	<input type="checkbox"/>	<input type="checkbox"/>		If yes, list health plan: _____
Student visa	<input type="checkbox"/>	<input type="checkbox"/>		
Tourist visa	<input type="checkbox"/>	<input type="checkbox"/>		
Employment visa	<input type="checkbox"/>	<input type="checkbox"/>		
Family/Fiance visa	<input type="checkbox"/>	<input type="checkbox"/>		
Refugee	<input type="checkbox"/>	<input type="checkbox"/>		
Asylee/Parolee	<input type="checkbox"/>	<input type="checkbox"/>		
Other _____	<input type="checkbox"/>	<input type="checkbox"/>		
Unknown _____	<input type="checkbox"/>	<input type="checkbox"/>		

BASIS OF DIAGNOSIS

SITE OF DISEASE (check all that apply) <input type="checkbox"/> Pulmonary <input type="checkbox"/> Pleural <input type="checkbox"/> Lymphatic <input type="checkbox"/> Cervical <input type="checkbox"/> Intrathoracic <input type="checkbox"/> Axillary <input type="checkbox"/> Other lymph _____ <input type="checkbox"/> Other _____	SYMPTOMATIC? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, ONSET on ____/____/____ SYMPTOMS: Cough (duration _____) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Hemoptysis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Night sweats <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Weight loss of ____lbs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Medical care for symptoms first sought on ____/____/____ Where? _____ If patient did not seek care for TB symptoms, primary reason for evaluation: <input type="checkbox"/> Contact investigation <input type="checkbox"/> Targeted testing <input type="checkbox"/> Employment/Administrative screening HCW? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> Immigration exam <input type="checkbox"/> Incidental abnormal CXR/CT <input type="checkbox"/> Incidental lab result <input type="checkbox"/> Other _____
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TST AT DIAGNOSIS ____/____/____ <input type="checkbox"/> Pos ____ mm <input type="checkbox"/> Neg ____ mm <input type="checkbox"/> Not Done	QFT AT DIAGNOSIS ____/____/____ <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not Done	PRIOR TST/QFT ____/____/____ <input type="checkbox"/> Pos ____ mm <input type="checkbox"/> Neg ____ mm <input type="checkbox"/> Not Done Documented? ____	CHEST IMAGING AT DIAGNOSIS (Attach copies of chest x-rays and CT reports) X-RAY ____/____/____ <input type="checkbox"/> Negative for TB <input type="checkbox"/> Abnormal non-cavitary, non-miliary <input type="checkbox"/> Abnormal, cavitary <input type="checkbox"/> Abnormal, miliary <input type="checkbox"/> Not done	CT ____/____/____ <input type="checkbox"/> Negative for TB <input type="checkbox"/> Abnormal, non-cavitary, non-miliary <input type="checkbox"/> Abnormal, cavitary <input type="checkbox"/> Abnormal, miliary <input type="checkbox"/> Not done
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BACTERIOLOGY

Source of Specimen*	Date Collected	AFB Smear	NAAT/PCR	Culture/DNA Probe	Pathology Notes	Lab Name (If not OSPHL submit copies of labs)
_____	____/____/____	4+ 3+ 2+ 1+ Neg <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pos Neg NA Pend <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pos Neg Pend <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	_____
_____	____/____/____	4+ 3+ 2+ 1+ Neg <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pos Neg NA Pend <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pos Neg Pend <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	_____
_____	____/____/____	4+ 3+ 2+ 1+ Neg <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pos Neg NA Pend <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pos Neg Pend <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	_____
_____	____/____/____	4+ 3+ 2+ 1+ Neg <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pos Neg NA Pend <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pos Neg Pend <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	_____

*Please indicate results of diagnostic specimens (e.g. include the first positive AFB smear and first positive MTB culture)



TB RISKS

TB HISTORY

Previous diagnosis of TB disease? Yes No Unk If yes, year _____ Was treatment completed? _____ If yes, where _____
 Previous treatment for LTBI? Yes No Unk If yes, year _____ Was treatment completed? _____ If yes, where _____

CONGREGATE SETTINGS

Homeless in the past year? Yes No Unk _____
 History of homelessness? Yes No Unk Describe _____
 Resident of correctional facility at diagnosis? Yes No Unk If yes, where _____
 History of incarceration? Yes No Unk If yes, when and where _____
 Resident of longterm care facility at diagnosis? Yes No Unk If yes, where _____

SOCIAL FACTORS

Excess alcohol use in the past year? Yes No Unk
 IV drug use in the past year? Yes No Unk
 Non-IV drug use in the past year? Yes No Unk
 Currently smoking* tobacco? Yes No Unk Tobacco type (cigarette, cigar, pipe) _____ Amount per day _____ Start year _____
 If not currently smoking, past tobacco smoking*? Yes No Unk Tobacco type _____ Amount per day _____ Start year _____ Quit year _____
 Travel outside the US longer than 30 days? Yes No Unk If yes, when and where _____
 * >100 cigarettes or equivalent amount in lifetime

MEDICAL RISKS

HIV at diagnosis ____/____/____ Pending
 Pos
 Neg
 Not done If not done, why? _____

Medical and Other Risk Factors (select all that apply)

Diabetes Post organ transplant
 Immunosuppressive therapy Weight <90% of ideal body weight
 TNF α antagonist therapy Cancer/malignancy
 End stage renal disease Other _____
 Previous contact to an infectious TB patient? Yes No Unk
 If yes, year _____ MDR? _____ Name of case _____

TREATMENT

DATE TREATMENT STARTED ____/____/____

Drug	Dosage	Frequency	Is therapy directly observed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Isoniazid	_____	_____	If no, why _____ Pt height _____ Pt weight _____ <input type="checkbox"/> History of hepatitis or other liver dysfunction If yes, provide details: _____
<input type="checkbox"/> Rifampin	_____	_____	
<input type="checkbox"/> Pyrazinamide	_____	_____	
<input type="checkbox"/> Ethambutol	_____	_____	
<input type="checkbox"/> _____	_____	_____	
<input type="checkbox"/> _____	_____	_____	

VERIFICATION (Please also update bacteriology section and HIV status if no longer pending)

Laboratory confirmed Clinical case Provider treating empirically Not TB: Other diagnosis _____

CLOSURE

REASON Not TB Completed treatment Lost Refused/noncompliant Died: Cause(s) of death _____ Adverse treatment event

<p>TREATMENT STOP DATE</p> <p>Date stopped ____/____/____ If tx >12 months, why? _____</p>	<p>Type of outpatient healthcare provider w/ primary responsibility for clinical decision making</p> <p><input type="checkbox"/> LHD <input type="checkbox"/> Inpatient care only <input type="checkbox"/> Private <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Institutional/correctional <input type="checkbox"/> Other _____</p>	<p>RESPONSE TO TREATMENT</p> <p>Did sputum culture convert? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Enter date of conversion ____/____/____ If no, why not _____</p> <p>Did CXR or CT improve? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Did symptoms improve? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p>TREATMENT DOSES</p> <p><i>In reporting LHD:</i> DOT doses _____ Non-DOT doses _____ Daily* _____ # weeks DOT _____ # doses DOT _____ Bi-weekly _____ # weeks _____ # doses _____ Other schedule _____ Describe dose schedule (ie, 3x/wk): _____</p> <p><i>Outside reporting LHD (for transfer cases):</i></p>		<p>DOT</p> <p><input type="checkbox"/> Fully directly observed <input type="checkbox"/> Self administered <input type="checkbox"/> Both directly observed and self administered If not full DOT, why? _____</p>

*Daily DOT includes weekday doses and excludes weekends and federal holidays

COMMENTS