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



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

1. Date Reported	3. Case Numbers								
·	Year Reported	(YYYY) State (Code Locally Assigned	Identification Number					
Month Day Year	State Case Number								
	City/County								
	Case Number								
2. Date Submitted				Reason:					
Month Day Year	Linking State Case Number								
	Linking State								
	Case Number								
4. Reporting Address for Case Counting			8. Date of Birth						
			Month Day	Year					
City									
Within City Limits (select one)	Yes No			<u> </u>					
County			9. Sex at Birth (select one)	11. Race (select one or more) American Indian or					
			☐ Male ☐ Female	☐ Alaska Native					
ZIP CODE			10. Ethnicity (select one)	Asian: Specify					
			Hispanic or Latino	☐ Black or African American ☐ Native Hawaiian or					
` <i>'</i>	. Date Counted Month Day	Year	Not Hispanic Other Pacific Islander						
Countable TB Case			or Latino Specify						
Count as a TB case				write varie					
Noncountable TB Case 7.	Previous Diagnosis of TB Diseas	se (select one)	12. Country of Birth	ad to a parent who was a LLS citizen)					
Verified Case: Counted by another U.S. area (e.g., county, state)	☐ Yes ☐ No		"U.Sborn" (or born abroad to a parent who was a U.S. citizer (select one) Yes No						
Verified Case: TB treatment			Country of birth: Specify						
initiated in another country	If YES, enter year of previous TB dis	sease diagnosis:	13. Month-Year Arrived in U.S.						
Specify			Month Year						
Verified Case: Recurrent TB within 12 months after completion of therapy									
			<u> </u>						
14. Pediatric TB Patients (<15 years old)		16. Site of TB	Disease (select all that apply)						
Country of Birth for Primary Guardian(s): Specify	у	_	_						
Guardian 1		☐ Pulmon	<u> </u>						
Guardian 2		Pleural	Genitou	rinary					
Patient lived outside U.S. for >2 months? (select one)	Yes No Unknown	Lympha	Lymphatic: Cervical Meningeal						
If YES, list countries, specify:		Lympha	atic: Intrathoracic Peritone	eal					
15. Status at TB Diagnosis (select one)		Lympha	atic: Axillary Other: E	Enter anatomic code(s)					
		Lympha	atic: Other Site not	stated (see list): (2					
Alive Dead Month	Day Year	Lympha	atic: Unknown	\					
If DEAD, enter date of death:		Larynge		3					
If DEAD, was TB a cause of death? (select one)	_								
Yes No	o Unknown								

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REPORT OF VERIFIED CASE OF TUBERCULOSIS

17. Sputum Smear (select one)	Date Collected:	`
Positive Not Done	Month Day Year	
l 🖂 🖂		
☐ Negative ☐ Unknown		
18. Sputum Culture (select one)	Date Collected: Date	Result Reported:
l <u> </u>		onth Day Year
Positive Not Done		
☐ Negative ☐ Unknown		
	Reporting Laboratory Type (select one): Public Health	☐ Commercial ☐ au
	Laboratory	Laboratory Other
	of Tissue and Other Body Fluids (select one)	
Positive Not Done	(aga l	anatomic code Type of exam (select all that apply):
☐ Negative ☐ Unknown	Month Day Year (See I	Smear Pathology/Cytology
20. Culture of Tissue and Other	Body Fluids (select one) Enter	
Positive Not Done	L)ate (Collected:	mic code Date Result Reported:
	Month Day Year	ist):
☐ Negative ☐ Unknown		
	Reporting Laboratory Type (select one): Public Health	Commercial Other
	Laboratory	Laboratory
21. Nucleic Acid Amplification	Fast Posult (solost and)	
l <u> </u>		
Positive Not Done		Date Result Reported:
☐ Negative ☐ Unknown	Month Day Year	Month Day Year
Indeterminate		
		Panarting Laboratory Type (collect and):
	Enter specimen type: Sputum	Reporting Laboratory Type (select one):
	OR If not Sputum, enter anatomic code (see list):	Public Health Commercial Laboratory Other
	in not opatam, enter anatomic code (see iist).	, , , , , , , , , , , , , , , , , , ,
Initial Chest Radiograph and Of	ther Chest Imaging Study	
OOA Initial Chart Badia avant		
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	□ Normal □ Abnormal* (consistent with TB) □ Not Done	Unknown
Other Chest Imaging		<u> </u>
Study (select one)	For ABNORMAL Initial Chest Radiograph: Evidence	the state of the s
		of a cavity (select one): Yes No Unknown
		of a cavity (select one): ☐ Yes ☐ No ☐ Unknown of miliary TB (select one): ☐ Yes ☐ No ☐ Unknown
		· · · ·
	Evidence	of miliary TB (select one):
23. Tuberculin (Mantoux) Skin T	Evidence	· · · ·
at Diagnosis (select one)	Evidence	of miliary TB (select one): Yes No Unknown 25. Primary Reason Evaluated for TB Disease (select one)
at Diagnosis (select one) Positive Not Done	Evidence	of miliary TB (select one): Yes No Unknown 25. Primary Reason Evaluated for TB Disease (select one) TB Symptoms
at Diagnosis (select one)	Test Date Tuberculin Skin Test (TST) Placed: Millimeters (mm)	of miliary TB (select one): Yes No Unknown 25. Primary Reason Evaluated for TB Disease (select one)
at Diagnosis (select one) Positive Not Done	Test Date Tuberculin Skin Test (TST) Placed: Millimeters (mm)	of miliary TB (select one): Yes No Unknown 25. Primary Reason Evaluated for TB Disease (select one) TB Symptoms
at Diagnosis (select one) Positive Not Done Negative Unknown	Test Date Tuberculin Skin Test (TST) Placed: Millimeters (mm) of induration: Month Day Year of induration:	of miliary TB (select one): Yes No Unknown 25. Primary Reason Evaluated for TB Disease (select one) TB Symptoms Abnormal Chest Radiograph (consistent with TB)
at Diagnosis (select one) Positive Not Done	Date Tuberculin Skin Test (TST) Placed: Month Day Year of induration: Assay Date Collected:	of miliary TB (select one): Yes No Unknown 25. Primary Reason Evaluated for TB Disease (select one) TB Symptoms Abnormal Chest Radiograph (consistent with TB) Contact Investigation
at Diagnosis (select one) Positive Not Done Negative Unknown	Test Date Tuberculin Skin Test (TST) Placed: Millimeters (mm) of induration: Month Day Year of induration: Assay Date Collected:	of miliary TB (select one): Yes No Unknown 25. Primary Reason Evaluated for TB Disease (select one) TB Symptoms Abnormal Chest Radiograph (consistent with TB) Contact Investigation Targeted Testing Health Care Worker
at Diagnosis (select one) Positive Not Done Negative Unknown 24. Interferon Gamma Release of Mycobacterium tubercul	Date Tuberculin Skin Test (TST) Placed: Month Day Year of induration: Assay Date Collected:	of miliary TB (select one): Yes No Unknown 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
at Diagnosis (select one) Positive Not Done Negative Unknown 24. Interferon Gamma Release of the Mycobacterium tubercul (select one) Positive Not Done	Date Tuberculin Skin Test (TST) Placed: Month Day Year Of induration: Assay Date Collected: Month Day Year Month Day Year	of miliary TB (select one): Yes No Unknown 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
at Diagnosis (select one) Positive Not Done Negative Unknown 24. Interferon Gamma Release of for Mycobacterium tuberculi (select one)	Date Tuberculin Skin Test (TST) Placed: Month Day Year of induration: Assay Date Collected:	of miliary TB (select one): Yes No Unknown 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

REPORT OF VERIFIED CASE OF TUBERCULOSIS 26. HIV Status at Time of Diagnosis (select one) Negative Indeterminate Not Offered Unknown Test Done, Results Unknown Positive Refused If POSITIVE, enter: City/County HIV/AIDS State HIV/AIDS Patient Number: Patient Number: Unknown □No Yes 27. Homeless Within Past Year 28. Resident of Correctional Facility at Time of Diagnosis (select one) (select one) If YES, (select one): If YES, under custody of Immigration and Customs Federal Prison Local Jail Other Correctional Facility Yes Unknown Enforcement? (select one) State Prison ☐ Juvenile Correction Facility Unknown □No Yes 29. Resident of Long-Term Care Facility at Time of Diagnosis (select one) □No Yes Unknown If YES, (select one): Unknown ☐ Nursing Home Residential Facility Alcohol or Drug Treatment Facility Mental Health Residential Facility Under Long-Term Care Facility 30. Primary Occupation Within the Past Year (select one) Retired Not Seeking Employment (e.g. student, homemaker, disabled person) Health Care Worker ☐ Migrant/Seasonal Worker ☐ Correctional Facility Employee ☐ Other Occupation Unemployed Unknown 31. Injecting Drug Use Within Past Year 32. Non-Injecting Drug Use Within Past Year 33. Excess Alcohol Use Within Past Year (select one) (select one) (select one) Unknown □No ☐ Yes Yes Unknown □No Unknown □No Yes 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) None TNF-α Antagonist Therapy End-Stage Renal Disease ☐ 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) ☐ Tourist Visa Not Applicable Immigrant Visa Asylee or Parolee Other Immigration Status Student Visa Family/Fiancé Visa • "U.S.-born" (or born abroad to a parent who was a U.S. citizen) Unknown Employment Visa Refugee . Born in 1 of the U.S. Territories, U.S. Island Areas, or U.S. Outlying Areas 36. Date Therapy Started 37. Initial Drug Regimen (select one option for each drug) No Yes Unk Yes Unk No Yes Unk Moxifloxacin Isoniazid **Ethionamide** ппп Amikacin Rifampin Cycloserine Para-Amino П Pyrazinamide Kanamycin Salicylic Acid Ethambutol Capreomycin Other Specify ППП Ciprofloxacin Streptomycin Other Levofloxacin Rifabutin Specify Rifapentine Ofloxacin Comments:

Patient's Name _				REPORT OF VERIFIE	RIFIED CASE
_	(Last)	(First)	(M.I.)	OF TUBERC	ULOSIS
Street Address					
		(Number, Str	eet, City, State)	(ZIP CODE)	

ODC
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REPORT OF VERIFIED CASE OF TUBERCULOSIS

(ZIP CODE) 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

Initial Drug Susceptibility Report	(Follow Up Report – 1)
Year Counted State Case Number City/County Case Number Submit this report for all culture-positive cases.	
38. Genotyping Accession Number	
Isolate submitted for genotyping (select one):	
If YES, genotyping accession number for episode:	
39. Initial Drug Susceptibility Testing	
Was drug susceptibility testing done? (select one)	
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	OR If not Sputum, enter anatomic code (see list):
40. Initial Drug Susceptibility Results (select one option for each drug)	
Resistant Susceptible Not Done Unknown	Resistant Susceptible Not Done Unknown
Comments:	

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Patient's Name				REPORT OF VERIFIED CASE
	(Last)	(First)	(M.I.)	OF TUBERCULOSIS
Street Address				0. 102200200.0

REPORT OF VERIFIED CASE OF TUBERCULOSIS

(Number, Street, City, State)

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

/Calland Lin Danard

ase Completion Report												(Fo	ollow Up Report
State Case Number City/County Case Number Case Number Case Number		which th		[aliva	at d	liagi	nos	ie			
41. Sputum Culture Conversion Documente				 □ _{Yes}		nknown		iagi	103	13.			
If YES, enter date specimen collected for F consistently negative sputum culture: Month Day Year		If NO, ent	er reasoi llow-up im Despi	n for not	docume	enting sp	outum	Patie	ent Re er Spe	efused	ı): Patient Lost to Follow-Up
Did the patient move during TB therapy? (s If YES, moved to where (select all that appl In state, out of jurisdiction (enter city/cc	ly):] _{Yes}			s	Specify	/				
Out of state (enter state)	Spe	cify					S _I	pecify _.					
Out of the U.S. (enter country)	Spe	cify					S _i	pecify _.					
If moved out of the U.S., transnational reference	rral? (sele	ect one)		No [Yes								
Month Day Year		Los	mpleted et cooperat	Therapy ive or Re	fused	□ No	ot TB ed	If	f DIED), indic	о ТВ с	ause of disease herapy	
45. Reason Therapy Extended >12 months (select all	that apply)											
Rifampin Resistance		Non-adhere	ence			Clir	nically	Indica	ited –	other	reaso	าร	
Adverse Drug Reaction		Failure				Oth	er Spe	ecify _					
46. Type of Outpatient Health Care Provider Local/State Health Department (HD) Private Outpatient		ll that apply) IHS, Tribal H Institutional			oration		□ In	patien	nt Care	e Only	,		Unknown
Comments:													

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	REPORT OF VERIFIED CASE
Case No.	OF TUBERCULOSIS

(Last)	(First)

State (



Patient's Name _

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

Case Completion Report - Continued (Follow Up Report - 2)

47. Directly Observed The	erapy (DOT)	(select one)								
☐ No, Totally Self-Adn	ninistered									
Yes, Totally Directly Observed										
Yes, Both Directly C	bserved an	d Self-Admini	stered							
Unknown										
Number of weeks of dir	rectly obser	ved therapy (Γ								
48. Final Drug Susceptibi	-									
Was follow-up drug su			(select one)	□No	Yes Unknown					
If NO or UNKNOWN		_								
If YES, enter date FINA						Sputum				
testing was done:					0	R				
Month Day		Year]		If	not Sputum	n, enter anato	mic code (se	ee list):	
49. Final Drug Susceptibi	ility Results	(select one o	ption for eac	ch drug)						
	Resistant	Susceptible	Not Done	<u>Unknown</u>		Resistant	Susceptible	Not Done	<u>Unknown</u>	
Isoniazid		П		П	Capreomycin					
Rifampin					Ciprofloxacin					
Pyrazinamide					Levofloxacin					
Ethambutol					Ofloxacin					
Streptomycin					Moxifloxacin					
Rifabutin					Other Quinolones					
Rifapentine					Cycloserine					
Ethionamide					Para-Amino Salicylic Acid					
Amikacin					Other	Ш		Ш	Ш	
Kanamycin					Specify				- п	
					Other Specify				ш	
									_	
Comments:										
									_	
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