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

	T						
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	- Case Number			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 City							
Within City Limits (select one)	Yes UNo			<u> </u>			
County			9. Sex at Birth (select one)	11. Race (select one or more)  American Indian or			
County	<del></del>		☐ Male ☐ Female	Alaska Native			
ZIP CODE			10. Ethnicity (select one)	Asian: Specify			
			☐ Hispanic or Latino ☐ Native Hawaiia				
1	Date Counted  Month Day	Year	'	Other Pacific Islander:			
Countable TB Case	North Bay	Tour	Not Hispanic or Latino	Specify White			
Count as a TB case							
Noncountable TB Case 7.	Previous Diagnosis of TB Diseas	se (select one)	12. Country of Birth	ad to a parent who was a U.S. citizen)			
Verified Case: Counted by another U.S. area (e.g., county, state)	□Yes □No		(select one) Yes				
Verified Case: TB treatment			Country of birth: Specify				
initiated in another country	f YES, enter year of previous TB dis	sease diagnosis:	13. Month-Year Arrived in I				
Specify			Month Year				
Verified Case: Recurrent TB within 12 months after completion of therapy							
			I				
14. Pediatric TB Patients (<15 years old)		16. Site of TB	Disease (select all that apply)				
Country of Birth for Primary Guardian(s): Specify		l _					
Guardian 1		Pulmon					
Guardian 2		Pleural Genitourinary					
(select one)	∕es ☐ No ☐ Unknown	Lympha	atic: Cervical	eal			
If YES, list countries, specify:		Lymphatic: Intrathoracic Peritoneal					
15. Status at TB Diagnosis (select one)		Lympha	atic: Axillary Site not	stated			
l — — — ·	ay Year	Lympha	atic: Other Other: E	inter anatomic site(s):			
Alive Dead Month D	ay Year	Lympha	Lymphatic: Unknown				
If DEAD, enter date of death:		Larynge	eal				
If DEAD, was TB a cause of death? (select one)							
☐ Yes ☐ No	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 R	lesult Reported:
	Month Day Year Mon	·
Positive Not Done		
☐ Negative ☐ Unknown		
	Reporting Laboratory Type (select one): Public Health	Commercial Other
	Laboratory	Laboratory
19. Smear/Pathology/Cytology of	of Tissue and Other Body Fluids (select one) Enter anatomic site:	
Positive Not Done	Date Collected:	
l	Month Day Year	T (
☐ Negative ☐ Unknown		Type of exam (select all that apply):
		Smear Pathology/Cytology
	Falson annahanatia athan	
20. Culture of Tissue and Other	Body Fluids (select one) Enter anatomic site:	
Positive Not Done	Date Collected:	Date Result Reported:
☐ Negative ☐ Unknown	Month Day Year	Month Day Year
	Reporting Laboratory Type (select one): Public Health Laboratory	Commercial Other
21. Nucleic Acid Amplification To	est Result (select one)	
Positive Not Done	Date Collected:	ate Result Reported:
☐ Negative ☐ Unknown	Month Day Year	Month Day Year
☐ Indeterminate		
	Enter specimen type: Sputum	eporting Laboratory Type (select one):
	OR	Public Health Commercial Other
If not Sputum, enter anatomic site:	:	Laboratory Laboratory
Initial Chest Radiograph and Otl		
initial Criest Natiograph and Oti	ier Oriest imaging Study	
22A. Initial Chest Radiograph	□ Normal □ Abnormal* (consistent with TB) □ Not Done	Unknown
(select one)	* For ABNORMAL Initial Chest Radiograph: Evidence of	of a cavity (select one): Yes No Unknown
	Evidence (	of miliary TB (select one): Yes No Unknown
22B. Initial Chest CT Scan or	· <del></del>	<u>_</u>
Other Chest Imaging	Normal Abnormal* (consistent with TB) Not Done	Unknown
Study (select one)	* For ABNORMAL Initial Chest Radiograph: Evidence of	
(	Evidence of	of miliary TB (select one): Yes No Unknown
		25 Primary Reason Evaluated for TR Disease
23. Tuberculin (Mantoux) Skin Te	∍st	25. Primary Reason Evaluated for TB Disease (select one)
at Diagnosis (select one)	est  Date Tuberculin Skin Test (TST) Placed: Millimeters (mm)	(select one)
at Diagnosis (select one)  Positive Not Done		(select one)  TB Symptoms
at Diagnosis (select one)	Date Tuberculin Skin Test (TST) Placed: Millimeters (mm)	(select one)
at Diagnosis (select one)  Positive Not Done	Date Tuberculin Skin Test (TST) Placed: Millimeters (mm)	(select one)  TB Symptoms
at Diagnosis (select one)  Positive Not Done  Negative Unknown	Date Tuberculin Skin Test (TST) Placed:  Millimeters (mm) of induration:  Month Day Year   Image: Placed   Ima	(select one)  TB Symptoms  Abnormal Chest Radiograph (consistent with TB)
at Diagnosis (select one)  Positive Not Done  Negative Unknown  24. Interferon Gamma Release A	Date Tuberculin Skin Test (TST) Placed:  Month Day Year  Of induration:  Date Collected:	(select one)  TB Symptoms  Abnormal Chest Radiograph (consistent with TB)  Contact Investigation  Targeted Testing
at Diagnosis (select one)  Positive Not Done  Negative Unknown	Date Tuberculin Skin Test (TST) Placed:  Millimeters (mm) of induration:  Month  Day  Year  Date Tuberculin Skin Test (TST) Placed:  Millimeters (mm) of induration:	(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 A for Mycobacterium tuberculor	Date Tuberculin Skin Test (TST) Placed:  Month Day Year  Of induration:  Date Collected:	(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 A for Mycobacterium tubercula (select one) Positive Not Done	Date Tuberculin Skin Test (TST) Placed:  Month  Day  Year  Date Collected:  Sis at Diagnosis  Month  Day  Year  Page 1  Millimeters (mm) of induration:  Year  Vear	(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 A for Mycobacterium tuberculo (select one)	Date Tuberculin Skin Test (TST) Placed:  Month Day Year  Of induration:  Date Collected:	(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 VERIFIED		
_	(Last)	(First)	(M.I.)	OF TUBERC	ULOSIS	
Street Address						
		(Number, Str	eet, 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

Initial Drug Susce	ptibility	Report					(F	ollow U	Jp Report
Year Counted	State Case Num City/Count Case Numl	y per							
Submit this repor		culture-	positiv	e cases.					
38. Genotyping Accession Isolate submitted for ge		lect one):		Yes					
If YES, genotyping acce	ssion numb	er for episode:	Γ						
39. Initial Drug Susceptibi	lity Testing								
Was drug susceptibility	testing done	? (select one)	□No	Yes	Unknown				
If NO or UNKNOWN,	do not coi	mplete the re	est of Follo	w Up Repor	t –1				
If YES, enter date FIRS testing was done:	isolate colle	ected for whic	h drug susc	eptibility	Enter specimen type: OR	Sputum			
Month Day	,	/ear	If not S	outum, enter a					
Isoniazid Rifampin Pyrazinamide Ethambutol Streptomycin Rifabutin Rifapentine Ethionamide	ity Results Resistant	(select one op	tion for each	h drug)  Unknown	Capreomycin Ciprofloxacin Levofloxacin Ofloxacin Moxifloxacin Other Quinolones Cycloserine Para-Amino Salicylic Acid	Resistant	Susceptible	Not Done	Unknown
Amikacin Kanamycin					Other Specify				
					Other  Specify	<u></u>	<u></u>		
Comments:									

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Patient's Name				REPORT OF VERIFIED CASE
	(Last)	(First)	(M.I.)	OF TUBERCULOSIS
Street Address				
		(Number, Str	eet, City, State)	(ZIP CODE)

CDC
SAFER-HEALTHIER-REORLE

### 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

Case Completion	า Report			(Follow Up Report – 2)
Year Counted	State Case Number			
	City/County Case Number			
Submit this repo	rt for all cases i	n which the patient was a	alive at diagnosis.	
41. Sputum Culture Con	version Documented (sel	ect one)	nknown	
	cimen collected for FIRST	If NO, enter reason for not docume	enting sputum culture conversion (select	t one):
consistently negative  Month Day	sputum culture: Year	No Follow-up Sputum Despite Induction	Patient Refused	Patient Lost to Follow-Up
I Day	Teal	No Follow-up Sputum and No	Induction Other Specify	
		Died	Unknown	
42. Moved				
·	during TB therapy? (select ere (select all that apply):	one) No Yes		
☐ In state, out of juri	sdiction (enter city/county)	City(s)	County(s)	
Out of state (enter		State(s)		
Out of the U.S. (en		untry(s)		
·	.S., transnational referral?			
43. Date Therapy Stoppe		44. Reason Therapy Stopped or N	lever Started (select one)	
		Completed Therapy		se of death (select one):
Month Day	Year	Lost	☐ Died ☐ Related to TB dis	sease Unrelated to TB disease
		Uncooperative or Refused	Other Related to TB the	erapy Unknown
		Adverse Treatment Event	Unknown	
45. Reason Therapy Ext	ended >12 months (selec			
Rifampin Resistan		Non-adherence	Clinically Indicated – other reasons	:
Adverse Drug Rea		Failure	Other Specify	
	lealth Care Provider (sele	ct all that apply)	, , _	
Local/State Health		IHS, Tribal HD, or Tribal Corporation	☐ Inpatient Care Only	Unknown
Private Outpatient	:	☐ Institutional/Correctional	Other	
Comments:				
(				

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	REPORT OF VERIFIED CASE
Case No.	OF TUBERCULOSIS

	(Last)	
456		

Patient's Name \_\_\_

State 0

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 Lin Report 2)

Case Completion Ne	port - Contin	lueu				(I	Ollow C	p neport – z		
47. Directly Observed Therapy	(DOT) (select one)									
No, Totally Self-Administe	ered									
Yes, Totally Directly Obser	rved									
Yes, Both Directly Observ	ed and Self-Admini	stered								
Unknown										
Number of weeks of directly observed therapy (DOT)										
48. Final Drug Susceptibility Testing										
Was follow-up drug susceptil	bility testing done?	(select one)	□No	Yes Unknown						
If NO or UNKNOWN, do r	not complete the	rest of Follo	w Up Rep	ort –2						
If YES, enter date FINAL isolatesting was done:	ate collected for wh	ich drug susce	eptibility	Enter specimen type: 0	Sputum					
Month Day	Year	-	_		••					
		If n	not Sputum,	enter anatomic site:						
40. Final Bour Constantibility B										
49. Final Drug Susceptibility Re			σ,		5	0 ""				
<u>Hesi</u>	istant Susceptible	_	<u>Unknown</u>		Resistant	Susceptible	Not Done	<u>Unknown</u>		
Isoniazid				Capreomycin						
				Ciprofloxacin						
- ,				Levofloxacin						
				Ofloxacin						
· · ·				Moxifloxacin						
				Other Quinolones						
· _				Cycloserine						
				Para-Amino Salicylic Acid						
				Other			Ш			
Kanamycin				Specify Other			П			
				Specify				_		
Comments:										
(										

(M.I.)

REPORT OF VERIFIED CASE OF TUBERCULOSIS

(First)

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