

Tuberculosis Disease

_____ COUNTY

REPORT AND DATE
 Initial ____/____/____
 Verification ____/____/____
 Closure ____/____/____

FOR STATE USE ONLY
 # _____
 VERIFIED
 Culture confirmed
 Clinical
 NOT VERIFIED

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 _____
 Phone () _____ - _____
 Date ____/____/____
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)	OCCUPATION
US Born/NA	<input type="checkbox"/>	<input type="checkbox"/>	Lived outside US >2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Health Care Worker <input type="checkbox"/> Other employment _____
Immigrant Visa	<input type="checkbox"/>	<input type="checkbox"/>	If yes, where _____	<input type="checkbox"/> Correctional Worker <input type="checkbox"/> Unemployed
Student Visa	<input type="checkbox"/>	<input type="checkbox"/>	Country of Birth of Guardians _____	<input type="checkbox"/> Migrant Worker <input type="checkbox"/> Retired
Tourist Visa	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Not seeking employment (eg student, disabled, homemaker) If not seeking, reason _____
Family/Fiance Visa	<input type="checkbox"/>	<input type="checkbox"/>		Worksite: _____
Refugee	<input type="checkbox"/>	<input type="checkbox"/>		HEALTH INSURANCE (select all that apply)
Asylee or Parolee	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Private <input type="checkbox"/> Public <input type="checkbox"/> None
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 _____ <input type="checkbox"/> _____	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 <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 _____ <input type="checkbox"/> Neg <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 <input type="checkbox"/> Cavitary <input type="checkbox"/> Miliary <input type="checkbox"/> Not Done CT ____/____/____ <input type="checkbox"/> Negative for TB <input type="checkbox"/> Abnormal <input type="checkbox"/> Cavitary <input type="checkbox"/> Miliary <input type="checkbox"/> Not Done
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BACTERIOLOGY

Source of Specimen*	Date Collected	AFB Smear	MTB Culture	Other (e.g. NAAT/PCR Test)	Lab Name (If not OSPHL submit copies of lab reports)
Sputum	____/____/____	4+ 3+ 2+ 1+ Neg <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pos Neg Pend <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 Pend <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 Pend <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 Pend <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 _____
 Previous contact to an infectious TB patient? Yes No Unk If yes, year _____ MDR? Name of case _____

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? _____

Other Medical Factors (select all that apply)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Post Organ Transplant
<input type="checkbox"/> Immunosuppressive Therapy	<input type="checkbox"/> Weight <90% of ideal body weight
<input type="checkbox"/> TNF α Antagonist Therapy	<input type="checkbox"/> Cancer/malignancy
<input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> Other _____

TREATMENT

DATE THERAPY STARTED ____/____/____

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

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 therapy Lost Refused/noncompliant Died: Cause(s) of death _____ Adverse treatment event

<p>IF STARTED ON THERAPY:</p> <p>Date stopped ____/____/____</p> <p>If tx >12 months, why? _____</p>	<p>Type of outpatient healthcare provider w/ primary responsibility for clinical decision making</p> <table border="0"> <tr> <td><input type="checkbox"/> LHD</td> <td><input type="checkbox"/> Inpatient care only</td> </tr> <tr> <td><input type="checkbox"/> Private</td> <td><input type="checkbox"/> Indian Health Services</td> </tr> <tr> <td><input type="checkbox"/> Institutional/correctional</td> <td><input type="checkbox"/> Other _____</td> </tr> </table>	<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>RESPONSE TO TREATMENT</p> <p>Did sputum culture convert? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p> <p>Enter date of conversion ____/____/____</p> <p>If no, why not _____</p> <p>Did CXR or CT improve? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p> <p>Did symptoms improve? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</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>TREATMENT WEEKS AND DOSES</p> <p><i>In reporting county:</i></p> <p>____# weeks DOT ____# doses DOT</p> <p>____# weeks ____# doses</p> <p><i>Outside reporting county (for transfer cases):</i></p> <p>____# weeks DOT ____# doses DOT</p> <p>____# weeks ____# doses</p>		<p>DOT</p> <p><input type="checkbox"/> Fully directly observed</p> <p><input type="checkbox"/> Self-administered</p> <p><input type="checkbox"/> Both directly observed and self administered</p> <p>If not full DOT, why? _____</p>						

COMMENTS