



Tuberculosis Surveillance Report Form

Complete for ALL TB Disease and Latent TB Infection

PATIENT INFORMATION

Patient Name – Last, First, Middle		Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other:	Date of Birth MM DD YYYY	Best Phone Number	Alternate Phone
Street Address		City	State	Zip	Ever Served in U.S. Military <input type="checkbox"/> Yes <input type="checkbox"/> No
Race (select one or more) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian (specify): _____ <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander (specify): _____			Ethnicity (select one) <input type="checkbox"/> Hispanic or Latino/a <input type="checkbox"/> Not Hispanic or Latino/a		Preferred Language _____
Country of Birth	Country of Usual Residence: _____		Country of Birth for Guardian(s) of TB patients <15 years old: _____		
Month-Year Arrived in U.S.	Country of Previous Residence for more than 60 days: _____		Travel for more than 30 days: _____		
Patient's Insurance Status <input type="checkbox"/> Uninsured <input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Medicaid <input type="checkbox"/> TB Medicaid		Status at Diagnosis <input type="checkbox"/> Alive <input type="checkbox"/> Dead Date of Death: MM DD YYYY	Current Occupation : Ever worked in: <input type="checkbox"/> Healthcare <input type="checkbox"/> Migrant/Seasonal <input type="checkbox"/> Correctional <input type="checkbox"/> None of the above facility		Most recent employer/school name and address: _____

SCREENING

Tuberculin (Mantoux) Skin Test (TST): Date Read: MM DD YYYY <input type="checkbox"/> Positive: _____ mm <input type="checkbox"/> Negative <input type="checkbox"/> Not done		Interferon Gamma Release Assay for Mycobacterium Tuberculosis (IGRA): Date Collected: MM DD YYYY <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Negative <input type="checkbox"/> Not Done <input type="checkbox"/> Borderline (T Spot Only) Test Type: <input type="checkbox"/> QuantiFERON <input type="checkbox"/> T-Spot.TB	
History of Negative TST? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Last Negative TST? MM YYYY	History of Latent TB Infection or TB Disease? <input type="checkbox"/> Disease Year: _____ <input type="checkbox"/> Infection Year: _____ <input type="checkbox"/> None	Smoking History <input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> Never

IMAGING – PLEASE ATTACH COPIES OF ALL IMAGING REPORTS

Initial Chest Radiograph (CXR) Date: MM DD YYYY <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Done If ABNORMAL: Evidence of a cavity <input type="checkbox"/> Yes <input type="checkbox"/> No Evidence of miliary TB <input type="checkbox"/> Yes <input type="checkbox"/> No		Other Imaging Study Select one: <input type="checkbox"/> CXR <input type="checkbox"/> CT Scan <input type="checkbox"/> MRI Date: MM DD YYYY <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Done If ABNORMAL: Evidence of a cavity <input type="checkbox"/> Yes <input type="checkbox"/> No Evidence of miliary TB <input type="checkbox"/> Yes <input type="checkbox"/> No	
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BACTERIOLOGY RESULTS – PLEASE ATTACH COPIES OF ALL RESULTS

#	Date Collected	Specimen Type	Smear	Nucleic Acid Amplification Test	Culture
1	MM DD YYYY	<input type="checkbox"/> Sputum <input type="checkbox"/> Fluid (specify): _____ <input type="checkbox"/> Tissue (specify): _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending	<input type="checkbox"/> Positive Rifampin resistance detected? <input type="checkbox"/> Negative <input type="checkbox"/> Yes <input type="checkbox"/> Indeterminate <input type="checkbox"/> No <input type="checkbox"/> Not Done <input type="checkbox"/> Not Done	<input type="checkbox"/> MTB + <input type="checkbox"/> MTB - <input type="checkbox"/> Pending <input type="checkbox"/> Non-TB sp.
2	MM DD YYYY	<input type="checkbox"/> Sputum <input type="checkbox"/> Fluid (specify): _____ <input type="checkbox"/> Tissue (specify): _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending	<input type="checkbox"/> Positive Rifampin resistance detected? <input type="checkbox"/> Negative <input type="checkbox"/> Yes <input type="checkbox"/> Indeterminate <input type="checkbox"/> No <input type="checkbox"/> Not Done <input type="checkbox"/> Not Done	<input type="checkbox"/> MTB + <input type="checkbox"/> MTB - <input type="checkbox"/> Pending <input type="checkbox"/> Non-TB sp.
3	MM DD YYYY	<input type="checkbox"/> Sputum <input type="checkbox"/> Fluid (specify): _____ <input type="checkbox"/> Tissue (specify): _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending	<input type="checkbox"/> Positive Rifampin resistance detected? <input type="checkbox"/> Negative <input type="checkbox"/> Yes <input type="checkbox"/> Indeterminate <input type="checkbox"/> No <input type="checkbox"/> Not Done <input type="checkbox"/> Not Done	<input type="checkbox"/> MTB + <input type="checkbox"/> MTB - <input type="checkbox"/> Pending <input type="checkbox"/> Non-TB sp.

DIAGNOSIS & EVALUATION

Diagnosis <input type="checkbox"/> TB Disease (specify site): _____ <input type="checkbox"/> Latent TB Infection	Reason for Evaluation <input type="checkbox"/> TB symptoms (onset date) MM DD YYYY <input type="checkbox"/> Contact investigation <input type="checkbox"/> Screening <input type="checkbox"/> Immigration or B1/B2 evaluation <input type="checkbox"/> Other: _____
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Patient Name: _____
 Last Middle First

HIV / HEPATITIS TESTING – ATTACH COPIES OF POSITIVE RESULTS

HIV Test Date MM DD YYYY	HIV Test Results <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Results pending <input type="checkbox"/> Refused	Hepatitis Test Date MM DD YYYY	Tests performed and results : <input type="checkbox"/> HBV <input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Not done <input type="checkbox"/> HCV <input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Not done
<input type="checkbox"/> CD4 # _____ Test Date: _____			

RISK FACTORS

Resident of Long Term Care Facility at the time of diagnosis? Yes, specify facility name: _____ No

Resident of Correctional Facility at the time of diagnosis? Yes, specify facility: _____ No

Resident of Correctional Facility at any time? Yes No

Within past year has the patient:

<input type="checkbox"/> Been homeless?	<input type="checkbox"/> Yes	If Yes, <input type="checkbox"/> Currently	<input type="checkbox"/> Within the last year	<input type="checkbox"/> Ever, when: _____	<input type="checkbox"/> No
<input type="checkbox"/> Used injection drugs?	<input type="checkbox"/> Yes	If Yes, <input type="checkbox"/> Currently	<input type="checkbox"/> Within the last year	<input type="checkbox"/> Ever, when: _____	<input type="checkbox"/> No
<input type="checkbox"/> Used other drugs?	<input type="checkbox"/> Yes	If Yes, <input type="checkbox"/> Currently	<input type="checkbox"/> Within the last year	<input type="checkbox"/> Ever, when: _____	<input type="checkbox"/> No
<input type="checkbox"/> Used excess alcohol?	<input type="checkbox"/> Yes	If Yes, <input type="checkbox"/> Currently	<input type="checkbox"/> Within the last year	<input type="checkbox"/> Ever, when: _____	<input type="checkbox"/> No

ADDITIONAL TB RISK FACTORS / MEDICAL CONDITIONS

Contact of infectious TB patient (<=2 years) If known case, give name of source case: _____

Incomplete LTBI treatment Diabetes mellitus: A1C _____ % or fasting blood glucose _____ Date of test: _____

Pregnant - Due date: _____ End stage renal disease: Immunosuppression (not HIV/AIDS), specify: _____

Tumor necrosis factor-alpha (TNF- α) antagonist therapy. Post-organ transplant: Cancer, specify: _____ None

TREATMENT

Initial treatment regimen – Please complete for all medications, include dosage per mg. Start Date: MM DD YYYY Expected Duration: _____ # of months	<input type="checkbox"/> Isoniazid..... <input type="checkbox"/> Rifampin <input type="checkbox"/> Ethambutol <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Pyridoxine (B6)....	<input type="checkbox"/> Rifapentine..... <input type="checkbox"/> Rifabutin..... <input type="checkbox"/> Other drug/dose <input type="checkbox"/> Other drug/dose	Please specify NON-TB medications, include dosage per mg or attach medication list. _____ _____ _____
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Directly Observed Therapy Performed by: <input type="checkbox"/> Local Health Dept. <input type="checkbox"/> VNA <input type="checkbox"/> DPH <input type="checkbox"/> Other, specify: _____	Preferred/Regular Pharmacy: Name: _____ Address: _____	Discharge/Treatment Plan Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No Copies sent to: <input type="checkbox"/> DPH <input type="checkbox"/> Local Health Dept.
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PROVIDER INFORMATION

Was patient hospitalized? <input type="checkbox"/> Yes If yes, discharge plan required <input type="checkbox"/> No	Medical Record Number	Date Admitted MM DD YYYY	Date Discharged MM DD YYYY
Admitting Hospital		Phone	
Attending Physician and Floor /Unit		Phone	
Discharge Planner/Care Coordinator Name		Phone	
Outpatient Facility/Clinic Name and Address		Fax	
Person Completing This Report		Phone	Date of This Report MM DD YYYY