Fax or mail to:
Connecticut Department of Public Health
Tuberculosis Control Program
410 Capitol Avenue, MS #11TUB
P.O. Box 340308
Hartford, CT 06134-0308
Phone: 860-509-7722 Fax: 860-509-7743

Tuberculosis Surveillance Report

Complete for ALL TB Disease and Latent TB Infection

Patient Name – Last, First, Middle	Sex at Birth	Date of Birth	Best Phone Number	Alternate Phone
	☐ Male ☐ Female ☐ Other (specify): _____	____|____|____ MM DD YYYY		

Street Address	City	State	Zip	Ever Served in U.S. Military
				☐ Yes ☐ No

Race (select one or more)
☐ American Indian/Alaska Native ☐ Asian (specify): _____ ☐ Black or African American
☐ White ☐ Native Hawaiian or Other Pacific Islander (specify): _____

Ethnicity (select one)
☐ Hispanic or Latino/a
☐ Not Hispanic or Latino/a

Preferred Language
_____

Country of Birth

Month-Year Arrived in U.S.

Immigration Status at First Entry to the U.S.
☐ Not applicable/U.S. born*
* U.S. born or born abroad to a parent who was a U.S. citizen.
* Born in 1 of the U.S. territories, U.S. Island areas or U.S. outlying areas

☐ Student Visa ☐ Family/Fiance Visa ☐ Other Immigration Status
☐ Employment Visa ☐ Refugee ☐ Immigrant Visa
☐ Tourist Visa ☐ Asylee or Parolee ☐ Unknown

Pediatric TB Patients (<15 years old)
Patient lived outside U.S. for > 2 months?
☐ Yes ☐ No
If YES, specify countries: _____

Country of Birth for Guardian(s) (specify)
Guardian 1: _____
Guardian 2: _____

Patient's Insurance Status
☐ Uninsured ☐ Private
☐ Medicare ☐ Other (specify): _____
☐ Medicaid

Status at Diagnosis
☐ Alive ☐ Dead
☐ Date of death: ____\|____\|____ MM DD YYYY

Primary Occupation in the past 12 months
☐ Health care worker ☐ Correctional employee ☐ Retired
☐ Migrant/Seasonal worker ☐ Not seeking employment (e.g. student, homemaker, disabled person) ☐ Unemployed
☐ Other occupation: _____ ☐ Unknown

Most recent employer/school name:

Employer/school address:

SCREENING

Tuberculin (Mantoux) Skin Test (TST):

Date Read: ____\|____\|____ MM DD YYYY

☐ Positive: _____ millimeters of induration
☐ Negative
☐ Not done

Interferon Gamma Release Assay for Mycobacterium Tuberculosis (IGRA):

Date Collected: ____\|____\|____ MM DD YYYY

☐ Positive ☐ Indeterminate
☐ Negative ☐ Not Done

Test Type
☐ QuantiFERON ☐ T-Spot.TB

History of Negative TST?
☐ Yes
☐ No

Date of Last Negative TST? ____\|____ MM YYYY

History of Latent TB Infection or TB Disease?
☐ Disease Year: _____
☐ Infection Year: _____
☐ None

IMAGING – ATTACH COPIES OF ALL IMAGING REPORTS

Initial Chest Radiograph (CXR)

Date: ____\|____\|____ MM DD YYYY

☐ Normal
☐ Abnormal
☐ Not Done

If ABNORMAL:
Evidence of a cavity ☐ Yes ☐ No
Evidence of miliary TB ☐ Yes ☐ No

Other Imaging Study Select one: ☐ CXR ☐ CT Scan ☐ MRI

Date: ____\|____\|____ MM DD YYYY

☐ Normal
☐ Abnormal
☐ Not Done

If ABNORMAL:
Evidence of a cavity ☐ Yes ☐ No
Evidence of miliary TB ☐ Yes ☐ No

BACTERIOLOGY RESULTS – ATTACH COPIES OF ALL RESULTS

#	Date Collected	Specimen Type	Smear	Nucleic Acid Amplification Test	Culture
1	____|____|____ MM DD YYYY	☐ Sputum ☐ Fluid (specify):_____ ☐ Tissue (specify): _____	☐ Positive ☐ Negative ☐ Pending	☐ Positive ☐ Negative ☐ Indeterminate ☐ Not Done; Rifampin resistant detected? ☐ Yes ☐ No ☐ Not Done	☐ (+) MTB ☐ Negative ☐ Pending ☐ Non-TB sp.
2	____|____|____ MM DD YYYY	☐ Sputum ☐ Fluid (specify):_____ ☐ Tissue (specify): _____	☐ Positive ☐ Negative ☐ Pending	☐ Positive ☐ Negative ☐ Indeterminate ☐ Not Done; Rifampin resistant detected? ☐ Yes ☐ No ☐ Not Done	☐ (+) MTB ☐ Negative ☐ Pending ☐ Non-TB sp.
3	____|____|____ MM DD YYYY	☐ Sputum ☐ Fluid (specify):_____ ☐ Tissue (specify): _____	☐ Positive ☐ Negative ☐ Pending	☐ Positive ☐ Negative ☐ Indeterminate ☐ Not Done; Rifampin resistant detected? ☐ Yes ☐ No ☐ Not Done	☐ (+) MTB ☐ Negative ☐ Pending ☐ Non-TB sp.

DIAGNOSIS & EVALUATION

Diagnosis
☐ TB Disease (specify site): _____
☐ Latent TB Infection

Reason for Evaluation
☐ TB symptoms (onset date) ____\|____\|____ MM DD YYYY ☐ Abnormal chest radiograph consistent with TB disease
☐ Contact investigation ☐ Targeted testing ☐ Health care worker ☐ Employment/Administrative testing
☐ Class B1/B2 evaluation ☐ Immigration medical exam ☐ Incidental lab report

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Patient Name: _____
Last First

HIV / HEPATITIS TESTING – ATTACH COPIES OF POSITVE RESULTS

HIV Test Date _____|_____|_____ (MM DD YYYY)

HIV Test Results: ☐ Negative ☐ Positive ☐ Indeterminate ☐ Results pending ☐ Refused

Hepatitis Test Date _____|_____|_____ (MM DD YYYY)

Tests performed: ☐ B ☐ C

Was patient positive for: ☐ B ☐ C

RISK FACTORS

Resident of Long Term Care Facility at Time of Diagnosis?
☐ Yes ☐ No If YES, please specify facility name and type:
_____
_____

Resident of Correctional Facility at Time of Diagnosis?
☐ Yes ☐ No If YES, specify facility:
_____

Resident of Correctional Facility at any time?
☐ Yes ☐ No

Within past year has the patient:
☐ Been homeless? ☐ Yes ☐ No
☐ Used injection drugs? ☐ Yes ☐ No
☐ Used other drugs? ☐ Yes ☐ No
☐ Used excess alcohol? ☐ Yes ☐ No

ADDITIONAL TB RISK FACTORS / MEDICAL CONDITIONS

☐ Contact of infectious TB patient (2 years or less)
☐ Contact of MDR-TB patient (2 years or less)
If known case, give name of source case: _____
☐ Missed contact (2 years or less)
☐ Incomplete Latent TB infection treatment
☐ Diabetes mellitus
☐ Pregnant - Due date: _____|_____|_____
☐ End stage renal disease
☐ Immunosuppression (not HIV/AIDS)
☐ Post-organ transplant
☐ Tumor necrosis factor-alpha (TNF-α) antagonist therapy.
☐ Cancer
☐ Smoking, if yes ☐ Curent ☐ Former
☐ None

Other medical conditions/comments:

TREATMENT

Initial treatment regimen – Please complete for all medications and dosages.

Start Date: _____|_____|_____ (MM DD YYYY)

Expected Duration (months)

☐ Isoniazid _____ mg	☐ Other_____ _____ mg	
☐ Rifampin _____ mg	☐ Other_____ _____ mg	
☐ Pyrazinamide _____ mg	☐ Other_____ _____ mg	
☐ Ethambutol _____ mg	**Please specify NON-TB medications:**	
☐ Pyridoxine (B6) _____ mg	_____ _____ mg	
☐ Rifapentine _____ mg	_____ _____ mg	
☐ Rifabutin _____ mg	_____ _____ mg	
☐ Other _____ _____ mg	_____ _____mg	

Are you requesting FREE medication from the DPH Tuberculosis Program?
☐ Yes ☐ No

IF YES, PLEASE ATTACH A PRESCRIPTION.

Directly Observed Therapy Performed by:
☐ Local Health Dept ☐ VNA ☐ DPH ☐ Other (specify) _____

Discharge/Treatment Plan Completed? ☐ Yes ☐ No

Copies sent to: ☐ Local Health Dept ☐ DPH

PROVIDER INFORMATION

Was patient hospitalized?	Medical Record Number	Date Admitted	Date Discharged
☐ Yes **If yes, discharge plan required** ☐ No		_____|_____|_____ (MM DD YYYY)	_____|_____|_____ (MM DD YYYY)

Admitting Hospital	Phone
Attending Physician	Beeper/Pager No./Cell
Outpatient Follow-up Physician for TB	
Outpatient Facility	Phone
Address	Fax

Person Completing This Report	Phone	Date of This Report
		_____|_____|_____ (MM DD YYYY)