Patient's Name: _____ (Last) (First) (M.I.)

Street Address: _____ (Number, Street, City, State) _____ Zip Code)

REPORT OF VERIFIED CASE OF TUBERCULOSIS

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)
ATLANTA, GEORGIA 30333

FORM APPROVED OMB NO. 0920-0026 Exp. Date 08/98

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

REPORT OF VERIFIED CASE OF TUBERCULOSIS

SOUNDEX ☐☐☐☐

1. State Reporting:
Specify: _____
Alpha State Code ☐☐

2. State Case Number: ☐☐☐☐☐☐☐☐☐
City/County Case Number: ☐☐☐☐☐☐☐☐☐

3. Date Submitted: Mo. ☐☐ Day ☐☐ Yr. ☐☐
By: _____

4. Address for Case Counting:
City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Within City Limits 1☐ Yes 2☐ No
County ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Zip Code ☐☐☐☐☐ — ☐☐☐☐

5. Month-Year Reported: Mo. ☐☐ Yr. ☐☐☐☐

6. Month-Year Counted: Mo. ☐☐ Yr. ☐☐☐☐

7. Date of Birth: Mo. ☐☐ Day ☐☐ Yr. ☐☐☐☐

8. Sex:
1☐ Male
2☐ Female

9. Race:
1☐ White 2☐ Black 3☐ American Indian or Alaskan Native
4☐ Asian or Pacific Islander: Specify (Optional) _____

10. Ethnic Origin:
1☐ Hispanic
2☐ Not Hispanic

11. Country of Origin:
If U.S., check here ☐
If not U.S., enter country code (see list) ☐☐

12. Month-Year Arrived in U.S.: Mo. ☐☐ Yr. ☐☐☐☐

13. Status at Diagnosis of TB:
1☐ Alive
2☐ Dead

14. Previous Diagnosis of Tuberculosis:
1☐ Yes
2☐ No
19 ☐☐ If yes, list year of previous diagnosis
1☐ If more than one previous episode, check here

15. Major Site of Disease:
00☐ Pulmonary
10☐ Pleural
21☐ Lymphatic: Cervical
22☐ Lymphatic: Intrathoracic
23☐ Lymphatic: Other
29☐ Lymphatic: Unknown
30☐ Bone and/or Joint
40☐ Genitourinary
50☐ Miliary
60☐ Meningeal
70☐ Peritoneal
80☐ Other*
90☐ Site not Stated
*If site is "Other", enter anatomic code (see list) ☐☐

16. Additional Site of Disease:
00☐ Pulmonary
10☐ Pleural
21☐ Lymphatic: Cervical
22☐ Lymphatic: Intrathoracic
23☐ Lymphatic: Other
29☐ Lymphatic: Unknown
30☐ Bone and/or Joint
40☐ Genitourinary
50☐ Miliary
60☐ Meningeal
70☐ Peritoneal
80☐ Other*
*If site is "Other", enter anatomic code (see list) ☐☐
If more than one additional site, check here ☐ 88

17. Sputum Smear:
1☐ Positive 3☐ Not Done
2☐ Negative 9☐ Unknown

18. Sputum Culture:
1☐ Positive 3☐ Not Done
2☐ Negative 9☐ Unknown

19. Microscopic Exam of Tissue and Other Body Fluids:
1☐ Positive 3☐ Not Done
2☐ Negative 9☐ Unknown
If positive, enter anatomic code(s) (see list) ☐☐ ☐☐

20. Culture of Tissue and Other Body Fluids:
1☐ Positive 3☐ Not Done
2☐ Negative 9☐ Unknown
If positive, enter anatomic code(s) (see list) ☐☐ ☐☐

21. Chest X-Ray:
1☐ Normal 2☐ Abnormal 3☐ Not Done 9☐ Unknown
If Abnormal *(check one)* 1☐ Cavitary 2☐ Noncavitary Consistent with TB 3☐ Noncavitary Not Consistent with TB
If Abnormal *(check one)* 1☐ Stable 3☐ Improving 2☐ Worsening 9☐ Unknown

22. Tuberculin (Mantoux) Skin Test at Diagnosis:
1☐ Positive 3☐ Not Done
2☐ Negative 9☐ Unknown
Millimeters (mm) of Induration ☐☐
If Negative, was patient anergic? 1☐ Yes 2☐ No 9☐ Unknown

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to DHHS Reports Clearance Officer; Paperwork Reduction Project (0920-0026); Rm 531H, H.H. Humphrey Bg.; 200 Independence Ave., SW, Washington, DC 20201.

Information contained on this form which would permit identification of any individual has been collected with a guarantee that it will be held in strict confidence, will be used only for surveillance purposes, and will not be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 U.S.C. 242m).

REPORT OF VERIFIED CASE OF TUBERCULOSIS

23. HIV Status:
0 ☐ Negative
1 ☐ Positive
2 ☐ Indeterminate
3 ☐ Refused
4 ☐ Not Offered
5 ☐ Test Done, Results Unknown
9 ☐ Unknown

If Positive, Based on: 1 ☐ Medical Documentation 2 ☐ Patient History 9 ☐ Unknown

If Positive, List: CDC AIDS Patient Number ☐☐☐☐☐☐☐ (If AIDS Reported before 1993)

State HIV/AIDS Patient Number ☐☐☐☐☐☐☐☐☐☐ (If AIDS Reported 1993 or Later)

City/County HIV/AIDS Patient Number ☐☐☐☐☐☐☐☐☐☐ (If AIDS Reported 1993 or Later)

24. Homeless Within Past Year:
0 ☐ No
1 ☐ Yes
9 ☐ Unknown

25. Resident of Correctional Facility at Time of Diagnosis: 0 ☐ No 1 ☐ Yes 9 ☐ Unknown

If Yes,
1 ☐ Federal Prison
2 ☐ State Prison
3 ☐ Local Jail
4 ☐ Juvenile Correctional Facility
5 ☐ Other Correctional Facility
9 ☐ Unknown

26. Resident of Long-Term Care Facility at Time of Diagnosis: 0 ☐ No 1 ☐ Yes 9 ☐ Unknown

If Yes,
1 ☐ Nursing Home
2 ☐ Hospital-Based Facility
3 ☐ Residential Facility
4 ☐ Mental Health Residential Facility
5 ☐ Alcohol or Drug Treatment Facility
6 ☐ Other Long-Term Care Facility
9 ☐ Unknown

27. Initial Drug Regimen:

	NO	YES	UNK.		NO	YES	UNK.		NO	YES	UNK.
Isoniazid	0 ☐	1 ☐	9 ☐	Ethionamide	0 ☐	1 ☐	9 ☐	Amikacin	0 ☐	1 ☐	9 ☐
Rifampin	0 ☐	1 ☐	9 ☐	Kanamycin	0 ☐	1 ☐	9 ☐	Rifabutine	0 ☐	1 ☐	9 ☐
Pyrazinamide	0 ☐	1 ☐	9 ☐	Cycloserine	0 ☐	1 ☐	9 ☐	Ciprofloxacin	0 ☐	1 ☐	9 ☐
Ethambutol	0 ☐	1 ☐	9 ☐	Capreomycin	0 ☐	1 ☐	9 ☐	Ofloxacin	0 ☐	1 ☐	9 ☐
Streptomycin	0 ☐	1 ☐	9 ☐	Para-Amino Salicylic Acid	0 ☐	1 ☐	9 ☐	Other	0 ☐	1 ☐	9 ☐

28. Date Therapy Started:
Mo. ☐☐ Day ☐☐ Yr. ☐☐

29. Injecting Drug Use Within Past Year:
0 ☐ No 1 ☐ Yes 9 ☐ Unknown

30. Non-Injecting Drug Use Within Past Year:
0 ☐ No 1 ☐ Yes 9 ☐ Unknown

31. Excess Alcohol Use Within Past Year:
0 ☐ No 1 ☐ Yes 9 ☐ Unknown

32. Occupation *(Check all that apply within the past 24 months):*
1 ☐ Health Care Worker
2 ☐ Correctional Employee
3 ☐ Migratory Agricultural Worker
4 ☐ Other Occupation
5 ☐ Not Employed within Past 24 Months
9 ☐ Unknown

Comments:

Patient's Name: _____ (Last) (First) (M.I.)

Street Address: _____ (Number, Street, City, State) _____ Zip Code)

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)
ATLANTA, GEORGIA 30333

FORM APPROVED OMB NO. 0920-0026 Exp. Date 8/98

Initial Drug Susceptibility Report

(Follow Up Report – 1)

SOUNDEX ☐☐☐☐

State Reporting:
Specify: _____
Alpha State Code ☐☐

Year Counted: ☐☐

State Case Number: ☐☐☐☐☐☐☐☐☐
City/County Case Number: ☐☐☐☐☐☐☐☐☐

Submit this report for all culture-positive cases.

33. Initial Drug Susceptibility Results:

Was Drug Susceptibility Testing Done: 0☐ No 1☐ Yes 9☐ Unknown

If answer is No or Unknown, do not complete rest of report.

If Yes,
Enter Date First Isolate Collected for Which Drug Susceptibility Was Done? Mo. ☐☐ Day ☐☐ Yr. ☐☐

34. Susceptibility Results:

	Resistant	Susceptible	Not Done	Unknown
Isoniazid	1☐	2☐	3☐	9☐
Rifampin	1☐	2☐	3☐	9☐
Pyrazinamide	1☐	2☐	3☐	9☐
Ethambutol	1☐	2☐	3☐	9☐
Streptomycin	1☐	2☐	3☐	9☐
Ethionamide	1☐	2☐	3☐	9☐
Kanamycin	1☐	2☐	3☐	9☐
Cycloserine	1☐	2☐	3☐	9☐
Capreomycin	1☐	2☐	3☐	9☐
Para-Amino Salicylic Acid	1☐	2☐	3☐	9☐
Amikacin	1☐	2☐	3☐	9☐
Rifabutine	1☐	2☐	3☐	9☐
Ciprofloxacin	1☐	2☐	3☐	9☐
Ofloxacin	1☐	2☐	3☐	9☐
Other	1☐	2☐	3☐	9☐

Comments:

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Patient's Name: _____ (Last) (First) (M.I.)

Street Address: _____ (Number, Street, City, State) _____ Zip Code)

REPORT OF VERIFIED CASE OF TUBERCULOSIS

REPORT OF VERIFIED CASE OF TUBERCULOSIS

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL
AND PREVENTION (CDC)
ATLANTA, GEORGIA 30333

FORM APPROVED OMB NO. 0920-0026 Exp. Date 8/98

Case Completion Report

(Follow Up Report – 2)

SOUNDEX ☐☐☐☐

State Reporting: Specify: _____ Alpha State Code ☐☐

Year Counted: ☐☐

State Case Number: ☐☐☐☐☐☐☐☐☐

City/County Case Number: ☐☐☐☐☐☐☐☐☐

35. Sputum Culture Conversion Documented:

0☐ No 1☐ Yes 9☐ Unknown

If Yes, Date Specimen Collected on Initial Positive Sputum Culture: Mo. ☐☐ Day ☐☐ Yr. ☐☐

If Yes, Date Specimen Collected on First Consistently Negative Culture: Mo. ☐☐ Day ☐☐ Yr. ☐☐

36. Date Therapy Stopped: Mo. ☐☐ Day ☐☐ Yr. ☐☐

37. Reason Therapy Stopped:

1☐ Completed Therapy 3☐ Lost 5☐ Not TB 7☐ Other
2☐ Moved 4☐ Uncooperative or Refused 6☐ Died 9☐ Unknown

38. Type of Health Care Provider:

1☐ Health Department
2☐ Private/Other
3☐ Both Health Department and Private/Other

39. Directly Observed Therapy:

0☐ No, Totally Self-Administered
1☐ Yes, Totally Directly Observed
2☐ Yes, Both Directly Observed and Self-Administered
9☐ Unknown

If Yes, Give Site(s) of Directly Observed Therapy:

1☐ In Clinic or Other Facility
2☐ In the Field
3☐ Both in Facility and in the Field
9☐ Unknown

Number of Weeks of Directly Observed Therapy: ☐☐☐ Weeks

40. Final Drug Susceptibility Results:

Was Follow-up Drug Susceptibility Testing Done? 0☐ No 1☐ Yes 9☐ Unk.

If answer is No or Unknown, do not complete rest of report.

If Yes, Enter Date Final Isolate Collected for Which Drug Susceptibility Was Done: Mo. ☐☐ Day ☐☐ Yr. ☐☐

41. Final Susceptibility Results:

	Resistant	Susceptible	Not Done	Unknown
Isoniazid	1☐	2☐	3☐	9☐
Rifampin	1☐	2☐	3☐	9☐
Pyrazinamide	1☐	2☐	3☐	9☐
Ethambutol	1☐	2☐	3☐	9☐
Streptomycin	1☐	2☐	3☐	9☐
Ethionamide	1☐	2☐	3☐	9☐
Kanamycin	1☐	2☐	3☐	9☐
Cycloserine	1☐	2☐	3☐	9☐
Capreomycin	1☐	2☐	3☐	9☐
Para-Amino Salicylic Acid	1☐	2☐	3☐	9☐
Amikacin	1☐	2☐	3☐	9☐
Rifabutine	1☐	2☐	3☐	9☐
Ciprofloxacin	1☐	2☐	3☐	9☐
Ofloxacin	1☐	2☐	3☐	9☐
Other	1☐	2☐	3☐	9☐

Comments:

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