REPORT OF VERIFIED CASE OF TUBERCULOSIS

DOH 343-232 November 2022

ADMINISTRATIVE INFORMATION

Date reported/LHJ notification date:

Month ☐☐ Day ☐☐ Year ☐☐☐☐

State Case Number: ☐☐☐☐ – ☐☐ – ☐☐☐☐☐☐☐☐☐

Local Case Number: ☐☐☐☐ – ☐☐ – ☐☐☐☐☐☐☐☐☐

Countable case?

- ☐ Yes
- ☐ No, counted by another US reporting area
  - State case number from other area: ☐☐☐☐ – ☐☐ – ☐☐☐☐☐☐☐☐☐
- ☐ No, treatment initiated in another country (Specify country: ____________________)
- ☐ No, recurrent TB within 12 months after completion of therapy
  - Prior state case number: ☐☐☐☐ – ☐☐ – ☐☐☐☐☐☐☐☐☐
- ☐ No, not a verified case of TB

DEMOGRAPHICS AND INITIAL EVALUATION

Reporting Address

City: ____________________ **Within city limits:** *(select one)* ☐ Yes ☐ No ☐ Unknown

County: ____________________ **Zip Code:** ____________________

Date of Birth:

Month ☐☐ Day ☐☐ Year ☐☐☐☐

(Enter '99' for unknown month or day or '9999' for unknown year)

Sex assigned at birth:

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ Unknown

Was patient pregnant at time of diagnostic evaluation?

- ☐ Yes
- ☐ No
- ☐ Unknown

Ethnicity:

- ☐ Hispanic, Latino/a, Latinx
- ☐ Non-Hispanic, Latino/a, Latinx
- ☐ Unknown
- ☐ Patient declined to respond

Race: *(Select all that apply)*

☐ Patient declined
☐ Unknown
☐ American Indian
☐ Alaska Native
☐ Asian

Specify: ☐ Asian Indian ☐ Bangladeshi ☐ Bhutanese ☐ Burmese ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Hmong
☐ Indonesian ☐ Iwo Jiman ☐ Japanese ☐ Karen ☐ Korean ☐ Laotian ☐ Madagascar ☐ Malaysian
☐ Maldivian ☐ Mien ☐ Nepalese ☐ Okinawan ☐ Pakistani ☐ Singaporean ☐ Sri Lankan ☐ Taiwanese
☐ Thai ☐ Vietnamese

☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander

Specify: ☐ Carolinian ☐ Chamorro ☐ Chuukese ☐ Fijian ☐ Guamanian ☐ Kiribati ☐ Kosraean ☐ Mariana Islander
☐ Marshallese ☐ Melanesian ☐ Micronesian ☐ Native Hawaiian ☐ New Hebrides ☐ Other Pacific Islander
☐ Palauan ☐ Papua New Guinean ☐ Pohnpeian ☐ Polynesian ☐ Saipanese ☐ Samoan ☐ Solomon Islander
☐ Tahitian ☐ Tokelauan ☐ Tongan ☐ Yapese

☐ White
☐ Other Race Not Listed Above

Specify: ☐ Afghan ☐ Afro-Caribbean ☐ Arab ☐ Central American ☐ Cham ☐ Chicano/a or Chicanx ☐ Congolese
☐ Cuban ☐ Dominican ☐ Egyptian ☐ Eritrean ☐ Ethiopian ☐ First Nations ☐ Indigenous-Latino/a or Latinx
☐ Iranian ☐ Iraqi ☐ Jordanian ☐ Kenyan ☐ Kuwaiti ☐ Lebanese ☐ Mestizo ☐ Mexican/Mexican-American
☐ Middle Eastern ☐ Moroccan ☐ North African ☐ Oromo ☐ Puerto Rican ☐ Romanian/Rumanian
☐ Russian ☐ Saudi Arabian ☐ Somali ☐ South African ☐ South American ☐ Syrian ☐ Ugandan
☐ Ukrainian ☐ Yemeni ☐ Other (Specify: ____________________)

DEMOGRAPHICS AND INITIAL EVALUATION (*continued*)

Country of birth: ______________________

If NOT United States or U.S. territory, date of first U.S. Arrival:

Month ☐☐ Day ☐☐ Year ☐☐☐☐

(Enter '99' for unknown month or day or '9999' for unknown year)

Eligible for U.S. citizenship/ nationality at birth (regardless of country of birth)?

- ☐ Yes
- ☐ No
- ☐ Unknown

Countries of birth for primary guardians: (*For pediatric cases only*)

Guardian 1: ______________________

Guardian 2: ______________________

Preferred language: ______________________

Country of usual residence:

____

If NOT U.S. reporting area, has been in US for ≥ 90 days (inclusive of report date)?

☐ Yes ☐ No ☐ Unknown

Status at TB diagnosis: ☐ Alive ☐ Dead

Initial reason evaluated for TB:

- ☐ Contact investigation
- ☐ Targeted testing
- ☐ Health care worker
- ☐ Employment/administrative testing
- ☐ Immigration medical exam
- ☐ TB symptoms
- ☐ Abnormal chest radiograph
- ☐ Incidental lab result
- ☐ Unknown
- ☐ Other (Specify: ______________________)

RISK FACTORS

Has patient *ever* worked as one of the following? *(Select all that apply)*

- ☐ Healthcare worker
- ☐ Correctional facility employee
- ☐ Migrant/seasonal worker
- ☐ None of the above
- ☐ Unknown

Patient's current occupation(s) and industry(ies): *(See reference manual for detailed instructions)*

Occupation	Industry
Ex: Registered Nurse	*Ex: Hospital*

Other risk factors: *(Select all that apply)*

Yes	No	Unk	
☐	☐	☐	Diabetic at diagnostic evaluation
☐	☐	☐	Has experienced homelessness in the past 12 months
☐	☐	☐	Has experienced homelessness ever
☐	☐	☐	Resident of correctional facility at diagnostic evaluation
☐	☐	☐	Resident of correctional facility ever
☐	☐	☐	Resident of long-term care facility at diagnostic evaluation
☐	☐	☐	Injecting drug use in the past 12 months
☐	☐	☐	Noninjecting drug use in the past 12 months
☐	☐	☐	Heavy alcohol use in the past 12 months
☐	☐	☐	TNF-α antagonist therapy
☐	☐	☐	Post-organ transplantation
☐	☐	☐	End stage renal disease
☐	☐	☐	Viral hepatitis (B or C only)
☐	☐	☐	Other immunocompromise (other than HIV/AIDS)
☐	☐	☐	Other risk factor(s) (Specify: ______________________)

If resident of correctional facility at diagnostic evaluation, type of facility?

- ☐ Federal prison
- ☐ State prison
- ☐ Local jail
- ☐ Juvenile correctional facility
- ☐ Other correctional facility
- ☐ Unknown

If resident of long-term care facility at diagnostic evaluation, type of facility?

- ☐ Nursing home
- ☐ Hospital-based facility
- ☐ Residential facility
- ☐ Mental health residential facility
- ☐ Alcohol or drug treatment facility
- ☐ Other long-term care facility
- ☐ Unknown

Current smoking status at diagnostic evaluation:

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Smoker, current status unknown
- ☐ Unknown if ever smoked

Lived outside of the United States for > 2 months (uninterrupted)?

- ☐ Yes
- ☐ No
- ☐ Unknown

If YES, specify country(ies): *(Optional)*

____

____

Patient's Name: ____________________ **State Case ID:** ____________________

DIAGNOSTIC TESTING (NON-DST)

Tuberculin skin test and all non-DST TB laboratory test results: *(Required results prefilled in table; unlimited number of additional results may be entered. If test not done, indicate so.)*

Test type	Specimen source site	Date collected/placed	Date reported/read	Test result (qual.)	Test result (quant.)	Test results (units of measure)
TST	Skin					Mm
IGRA [specify type]	Blood					N/A
Smear					N/A	N/A
Culture					N/A	N/A
NAA					N/A	N/A
HIV	Blood				N/A	N/A
CD4 count						
Hemoglobin A1c						
Fasting blood glucose						
Other (Specify:_____)						

Test type options: *Smear, Pathology, Cytology, NAA, Culture, TST, IGRA-QFT, IGRA-TSpot, IGRA-Other, IGRA-Unknown, HIV, CD4 Count, Hemoglobin A1c, Fasting blood glucose, Other (Specify)*
Test result (qualitative) options*: Positive, Negative, Indeterminate, Not done, Unknown, Refused, Test done result unknown, Not offered*
Test result (units of measure) options: *Millimeters of induration (TST), Cell count (CD4), Percentage (HGB-A1c), Milligrams per deciliter (FBG), Other units as appropriate*

Chest radiograph or other chest imaging study results: *(Required results prefilled in table; unlimited number of additional results may be entered. If test not done, indicate so.)*

Study type	Date of study	Result	Cavity?	Miliary?
Plain chest X-Ray				
CT scan				

Study type options: *Plain chest X-ray, CT scan, MRI, PET, Other*
Result options: *Not consistent with TB, Consistent with TB, Not done, Unknown*
Cavity options: *Yes, No, Unknown*
Miliary Options: *Yes, No, Unknown*

CLINICAL HISTORY AND FINDINGS

Has the patient been previously diagnosed with TB disease or LTBI?

- ☐ **Yes**
- ☐ **No**
- ☐ **Unknown**

If YES, complete table to the right *(Unlimited number of rows may be entered)*

Diagnosis type *(TB disease / LTBI)*	Date of diagnosis	Previous state case number	Completed treatment? *(Yes/No/Unknown)*

Date of illness onset/symptom start date:

Month ☐☐ **Day** ☐☐ **Year** ☐☐☐☐

(Enter '99' for unknown month or day or '9999' for unknown year)

Site of TB disease: *(Select all that apply)*

- ☐ **Pulmonary/Lung Structure**
- ☐ **Pleural**
- ☐ **Lymphatic: Cervical**
- ☐ **Lymphatic: Intrathoracic**
- ☐ **Lymphatic: Axillary**
- ☐ **Lymphatic: Other**
- ☐ **Lymphatic: Unknown**
- ☐ **Laryngeal**
- ☐ **Bone, Joint, and/or Soft Tissue**
- ☐ **Other (Specify: ______________________)**
- ☐ **Genitourinary**
- ☐ **Meningeal**
- ☐ **Peritoneal**
- ☐ **Site not stated**

EPIDEMIOLOGIC INVESTIGATION

Case meets binational reporting criteria?

- ☐ Yes
- ☐ No
- ☐ Unknown

If YES, which criteria were met? *(Select all that apply)*

- ☐ Exposure to suspected product from Canada or Mexico *(e.g., dairy product for M. bovis case)*
- ☐ Has case contacts in or from Mexico or Canada
- ☐ Potentially exposed by a resident of Mexico or Canada
- ☐ Potentially exposed while in Mexico or Canada
- ☐ Resident of Canada or Mexico
- ☐ Other situations that may require binational notification or coordination of response

Case identified during the contact investigation of another case?

- ☐ Yes
- ☐ No
- ☐ Unknown

If YES, evaluated for TB during that contact investigation?

- ☐ Yes
- ☐ No
- ☐ Unknown

Contact investigation conducted for this case?

- ☐ Yes
- ☐ No
- ☐ Unknown

Were contacts identified?

- ☐ Yes
- ☐ No
- ☐ Unknown

Complete table below for all known TB and LTBI cases epidemiologically linked to this case
(An unlimited number of rows may be entered in WDRS)

State case number (RVCT #)
2020-WA-999999999

Known exposure(s): *(Optional)*

- ☐ Contact of MDR TB Patient (2 years or less)
- ☐ Contact of infectious TB patient (2 years or less)

INITIAL TREATMENT INFORMATION

Date therapy started:
(See RVCT Instruction Manual for hierarchy to determine date therapy started)

Month ☐☐ Day ☐☐ Year ☐☐☐☐

Initial drug regimen:

Yes	No	Unk		Yes	No	Unk	
☐	☐	☐	Isoniazid	☐	☐	☐	Levofloxacin
☐	☐	☐	Rifampin	☐	☐	☐	Ofloxacin
☐	☐	☐	Pyrazinamide	☐	☐	☐	Moxifloxacin
☐	☐	☐	Ethambutol	☐	☐	☐	Other Fluoroquinolones
☐	☐	☐	Streptomycin	☐	☐	☐	Cycloserine
☐	☐	☐	Rifabutin	☐	☐	☐	Para-Amino Salicylic Acid
☐	☐	☐	Rifapentine	☐	☐	☐	Linezolid
☐	☐	☐	Ethionamide	☐	☐	☐	Bedaquiline
☐	☐	☐	Amikacin	☐	☐	☐	Delaminid
☐	☐	☐	Kanamycin	☐	☐	☐	Clofazimine
☐	☐	☐	Capreomycin	☐	☐	☐	Pretomanid
☐	☐	☐	Ciprofloxacin				
☐	☐	☐	Other (Specify: ______________________)				

If initial drug regimen NOT RIPE/HRZE (Rifampin, Isoniazid, Pyrazinamide, and Ethambutol) why not? *(Select one)*

- ☐ Drug contraindication/interaction
- ☐ Drug susceptibility testing results already known
- ☐ Suspected drug resistance
- ☐ Drug shortage
- ☐ Other (Specify: ______________________)
- ☐ Unknown

Anticipated treatment duration: *(Optional)*

- ☐ 4 months
- ☐ 6 months
- ☐ 9 months
- ☐ 12 months
- ☐ 18 months
- ☐ 24 months
- ☐ Other, (Specify:______________________)

INITIAL TREATMENT INFORMATION (continued)

Was phenotypic/growth-based drug susceptibility testing done? ☐ **Yes** ☐ **No** ☐ **Unknown**

If YES, complete table below *(An unlimited number of rows may be entered)*
Include initial result for all drugs listed as well as any subsequent tests where results changed

Drug name	Date collected	Date reported	Specimen source	Result
Isoniazid				
Rifampin				
Pyrazinamide				
Ethambutol				
Streptomycin				
Rifabutin				
Rifapentine				
Ethionamide				
Amikacin				
Kanamycin				
Capreomycin				
Ciprofloxacin				
Levofloxacin				
Ofloxacin				
Moxifloxacin				
Other Quinolones				
Cycloserine				
Para-Amino Salicylic Acid				
Linezolid				
Bedaquiline				
Delamanid				
Clofazimine				
Pretomanid				
Other (Specify:___________)				

Result Options: *Resistant, Susceptible, Not done, Unknown*

Was genotypic/molecular drug susceptibility testing done? ☐ **Yes** ☐ **No** ☐ **Unknown**

If YES, complete table below *(an unlimited number of rows may be entered)*
Include initial result for each combination of gene and test type as well as any subsequent tests where the result changed

Gene name	Date collected	Date reported	Specimen source	Result	Nucleic acid change	Amino acid change	INDEL	Test type

Results options: *Mutation detected, Mutation not detected, Unknown* ***Indel options:*** *Insertion, Deletion, Indel (not otherwise specified), Unknown*
Test type options: *Nonsequencing, Sequencing, Other, Unknown*

Was the patient treated as an MDR TB case (regardless of DST results)? ☐ **Yes** ☐ **No** ☐ **Unknown**

If YES, complete MDR TB Supplemental Data Form

CASE OUTCOME

Sputum culture conversion documented?

- ☐ Yes
- ☐ No
- ☐ Unknown

If YES, date specimen collected for FIRST consistently negative sputum culture:

Month ☐☐ Day ☐☐ Year ☐☐☐☐

If NO, reason for not documenting sputum culture conversion?

- ☐ No follow-up sputum despite induction
- ☐ No follow-up sputum and no induction
- ☐ Died
- ☐ Patient refused
- ☐ Patient lost to follow-up
- ☐ Other (Specify: ____________________)
- ☐ Unknown

Moved during therapy?

- ☐ Yes
- ☐ No
- ☐ Unknown

If YES, moved to where? *(Select all that apply)*

- ☐ In-State (out of jurisdiction) (Specify County/City: ____________________)
- ☐ Out of State (Specify destination: ____________________)
- ☐ Out of United States (Specify destination: ____________________)

Transnational referral made?

- ☐ Yes
- ☐ No
- ☐ Unknown

Date therapy stopped: *(See RVCT Instruction Manual for hierarchy to determine date therapy stopped)*

Month ☐☐ Day ☐☐ Year ☐☐☐☐

Reason therapy stopped or never started? *(Select one)*

- ☐ Completed treatment
- ☐ Lost
- ☐ Patient choice (uncooperative or refused)
- ☐ Adverse treatment event
- ☐ Not TB
- ☐ Died
- ☐ Dying (treatment stopped because of imminent death, regardless of cause of death)
- ☐ Other (Specify: ____________________)
- ☐ Unknown

Reason TB disease therapy extended >12 months, if applicable: *(Select all that apply)*

- ☐ Inability to use Rifampin (resistance, intolerance, etc.)
- ☐ Adverse drug reaction
- ☐ Nonadherence
- ☐ Failure
- ☐ Clinically indicated for reasons other than above
- ☐ Other (Specify: ____________________)
- ☐ Unknown

Treatment administration: *(Select all that apply)*

- ☐ DOT (Directly Observed Therapy, in person)
- ☐ EDOT (Electronic DOT, via video call or other electronic method)
- ☐ Self-administered

Did the patient die (either before diagnosis or at any time while being followed by TB program)?

- ☐ Yes
- ☐ No
- ☐ Unknown

If YES, date of death:

Month ☐☐ Day ☐☐ Year ☐☐☐☐

Did TB or complications of TB treatment contribute to death?

- ☐ Yes
- ☐ No
- ☐ Unknown

Type of outpatient healthcare provider: *(Optional)*

- ☐ Local/state health department
- ☐ Private outpatient
- ☐ IHS, Tribal HD, or Tribal Corporation
- ☐ Other (Specify: ____________________)
- ☐ Institutional/correctional
- ☐ Inpatient care only
- ☐ Unknown

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