WV-DTBE

REPORT OF VERIFIED CASE OF TUBERCULOSIS

NAME______________________________ **TELEPHONE #**______________________

ADDRESS:______________________________ **SEX:**____M ____F **DATE OF BIRTH:**________________

______________ZIP__________COUNTY______________

Within City Limits: ___Yes ___No

HOMELESS WITHIN PAST YEAR: ____Yes ____No.

COUNTRY OF BIRTH:

_____ U.S.-BORN (or born abroad to U.S. citizen.)

_____ Other (Specify)______________________

Month/Year Arrived in U.S. ____________________

RACE: ____Amer.Ind/Alask.Nav. _____Asian: *Specify*______________

____Black ____Nav.Haw/Pac.Is: *Specify*__________ White______

ETHNIC ORIGIN: ______Hispanic ______Non-Hispanic

PEDIATRIC TB PATIENTS (< 15 y/o)

Country of Birth for Primary Guardian(s): *Specify*

Guardian 1______________________________

Guardian 2______________________________

Patient lived outside US > 2 mos? _____Yes _____No

If YES, list countries, *specify:*____________________

SITE OF DISEASE: **Previous Dx of TB? ___Yes ___No**

_____ Pulmonary _____ Lymphatic: Cervical

_____ Pleural _____ Lymphatic: Intrathoracic

_____ Laryngeal _____ Lymphatic: Axillary

_____ Bone / Joint _____ Lymphatic: Other

_____ Genitourinary _____ Peritoneal

_____ Meningeal _____ Other (Specify) ______________

STATUS AT TB DIAGNOSIS: _____ Alive _____ Dead

If DEAD, date of death:____________.

TB cause of death? ____ Yes ____ No

SPUTUM: Collected:__________

Smear: _____ Positive _____ Negative _____ Not Done

Culture: _____Positive _____Negative _____Not Done

Result Reported:__________

Type of Lab: _____Public Health _____Commercial _____Other

TISSUE AND OTHER BODY FLUIDS: **Specimen type:**______________________ **Collected:**____________

Type of Exam: ____Smear ____Pathology/Cytology

____Positive ____Negative ____Not Done

Culture: ____Positive ____Negative ____Not Done

Result Reported:__________

Type of Lab: _____Public Health _____Commercial _____Other

NUCLEIC ACID AMPLIFICATION TEST RESULT: **Specimen type:**______________

_____ Positive _____ Indeterminate _____ Negative _____ Not Done

Collected:______________ Reported:______________

Type of Lab: ______Public Health ______Commercial _____Other

INITIAL CHEST RADIOGRAPH AND OTHER CHEST IMAGING STUDY

Chest X-ray: DATE:____________ _____ Normal _____ Abnormal (consistent with TB) _____Not Done

For ABNORMAL Initial Chest X-ray: Evidence of a **Cavity**? ____Yes ____No; Evidence of **miliary** TB? ____Yes ____No

Other Chest Imaging: DATE:____________ _____ Normal _____ Abnormal (consistent with TB) _____Not Done

For ABNORMAL Initial Chest X-ray: Evidence of a Cavity? ____Yes ____No; Evidence of miliary TB? ____Yes ____No

TUBERCULIN (Mantoux) SKIN TEST AT DIAGNOSIS:

_____Positive _______ mms Date given:______________

_____Negative _____ Not Done

INTERFERON GAMMA RELEASE ASSAY FOR MTB AT DIAGNOSIS:

_____Positive ____Indeterminate Collected:______________

_____Negative ____Not Done Type__________________

HIV STATUS AT TIME OF DIAGNOSIS: *(select one)*

____Negative ____Indeterminate ____Not Offered

____Positive ____Refused ____Test Done, Results Unknown

If POSITIVE, enter State HIV/AIDS #: __ __ __ __ __ __ __ __ __ __

PRIMARY REASON EVALUATED FOR TB DISEASE (*select one*):

____ TB Symptoms

____ Abn. CXR (consistent with TB)

____ Contact Investigation

____ Targeted Testing

____ Health Care Worker

____ Employment/Administrative Testing

____ Immigration Medical Exam

____ Incidental Lab Result

RESIDENT OF CORRECTIONAL FACILITY AT TIME OF DIAGNOSIS: ____ **No** ____**YES**

If **YES,** (*select one*) _____Federal Prison ____State Prison ____Local Jail

____Juvenile Correctional Facility ____Other Corr. Facility

If YES, under custody of Immigration and Customs Enforcement? _____No ____Yes

RESIDENT OF LONG-TERM CARE FACILITY AT TIME OF DIAGNOSIS

____No ____**YES**

If **YES,** ____Nursing Home ____Residential Facility ____Alcohol/ Drug Treatment Facility

____Hospital-Based Facility ____Mental Health Residential Facility ____Other LTC Facility

Patient's Name ____________________ State Case No.____________

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PRIMARY OCCUPATION WITHIN THE PAST YEAR (*select one*)

____Health Care Worker ____Migrant/Seasonal Worker ____Not seeking Employment (e.g. student, homemaker, disabled)
____Correctional Facility Emp. ____Other Occupation ____Retired ____Unemployed

Injecting Drug Use Within Past Year	Non-Injecting Drug Use Within Past Year	Excess Alcohol Use Within Past Year
____No ____Yes	____No ____Yes	____No ____Yes

ADDITIONAL TB RISK FACTORS (*select all that apply*) ____Other *Specify* ____________

____Contact of MDR-TB Patient (≤ 2 yrs) ____Incomplete LTBI Tx ____Diabetes Mellitus ____Smokes
____Contact of Infectious TB Patient (≤ 2 yrs) ____TBF-α Antagonist Tx ____End-Stage Renal Disease ____None
____Missed Contact (≤ 2 yrs) ____Post-organ Transplantation ____Immunosuppression (not HIV/AIDS)

IMMIGRATION STATUS AT FIRST ENTRY TO THE U.S. (*select one*)

____Not Applicable ____Immigrant Visa ____Tourist Visa ____Asylee or Parolee
* "U.S.-born" (or born abroad to a parent who was a U.S. citizen) ____Student Visa ____Family/Fiancé Visa
* Born in 1 of U.S. Teritories, U.S. Island Areas, or U.S. Outlying Areas ____Employment Visa ____Refugee ____Other Immigration Status

DATE THERAPY STARTED (Month-Day-Year) : ____ ____ ________

INITIAL DRUG REGIMEN (*select one option for each drug*)

	No	Yes	Unk	Dosage	Date Started		No	Yes	Unk	Dosage	Date Started
Isoniazid	___	___	___	________	________	Capreomycin	___	___	___	________	________
Rifampin	___	___	___	________	________	Ciproflolacin	___	___	___	________	________
Pyrazinamide	___	___	___	________	________	Levofloxacin	___	___	___	________	________
Ethambutol	___	___	___	________	________	Ofloxacin	___	___	___	________	________
Streptomycin	___	___	___	________	________	Moxifloxacin	___	___	___	________	________
Rifabutin	___	___	___	________	________	Cycloserine	___	___	___	________	________
Rifapentine	___	___	___	________	________	PAS	___	___	___	________	________
Ethionamide	___	___	___	________	________	________	___	___	___	________	________
Amikacin	___	___	___	________	________	________	___	___	___	________	________
Kanamycin	___	___	___	________	________	________	___	___	___	________	________

COMMENTS: ____________________

PHYSICIAN'S NAME & ADDRESS:

____
____
____

Telephone:____________ Fax:____________

Reported by:____________________ **Date**:____________

Telephone:____________________