Form approved
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The EDN Tuberculosis Follow-Up Worksheet for Newly-Arrived Persons with Overseas Tuberculosis Classifications

A. Demographic

A1. Name (Last, First, Middle):	A2. Alien #:	A3. Visa type:	A4. Initial U.S. entry date:

A5. Age:	A6. Sex:	A7. DOB: ___/___/_____	A8. TB Class Based on *Technical Instructions for Panel Physicians*:

A9. Country of examination:

A10. Country of birth:

A11a. Name in care of:

A11b. Phone number:

A11c. Address:

A12a. Sponsor agency name:

A12b. Phone number:

A12c. Address:

B. Jurisdictional Information

B1. Arrival jurisdiction:

B2. Current jurisdiction:

C. U.S. Evaluation

C1. Date of first U.S. test or provider/clinic visit: _____/_____/_____

Mantoux Tuberculin Skin Test (TST) in U.S.

C2a. Was a TST administered in the U.S.?

☐ Yes ☐ No ☐ Unknown

*If **YES**,* C2b. TST placement date: ____/_____/_____

☐ Placement date uknown

C2c. TST mm: _____ ☐ Unknown

C2d. TST interpretation:

☐ Positive ☐ Negative ☐ Unknown

C2e. History of Previous Positive TST:

☐ Yes ☐ No ☐ Unknown

Interferon-Gamma Release Assay (IGRA) in U.S.

C3a. Was IGRA performed? ☐ Yes ☐ No ☐ Unknown

*If **YES**,* C3b. Date collected: ____/____/_____ ☐ Date unknown

_____ IUs/Spots

C3c. IGRA brand:

☐ QuantiFERON® ☐ T-SPOT

☐ Other (specify): _____

C3d. Result: ☐ Positive ☐ Negative ☐ Indeterminate, Borderline, or Equivocal ☐ Invalid ☐ Unknown

C3e. History of previous positive IGRA:

☐ Yes ☐ No ☐ Unknown

U.S Review of Pre-Immigration CXR

C4. Pre-immigration CXR available?

☐ Yes ☐ No ☐ Unknown

C5. U.S. interpretation of pre-immigration CXR:

☐ Normal (Negative for TB)
☐ Abnormal
  ☐ Suggestive of TB
  ☐ Non-TB Condition
☐ Poor Quality/Not Interpretable
☐ Unknown

U.S. Domestic CXR

C6a. U.S. domestic CXR done?

☐ Yes ☐ No ☐ Unknown

*If **YES**,* C6b. Date of U.S. CXR: ____/____/_____

C7. Interpretation of U.S. CXR:

☐ Normal (Negative for TB)
☐ Abnormal
  ☐ Suggestive of TB
  ☐ Non-TB Condition
☐ Poor Quality/Not Interpretable
☐ Unknown

Comparison

C8. U.S. domestic CXR comparison to pre-immigration CXR:

☐ Stable
☐ Worsening
☐ Improving
☐ Unknown

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Alien #

U.S. Review of Pre-Immigration Treatment

C9a. Completed treatment pre-immigration? ☐ Yes ☐ No ☐ Unknown

*If **YES**,* C9b. ☐ Treated for TB disease ☐ Treated for LTBI ☐ Treated, but unknown if TB disease or LTBI

*If **Treated for TB disease**,*

☐ Treatment completed **prior** to panel physician examination

☐ Treatment completed **after** panel physician diagnosis (DS 3030)

- ☐ At designated DOT site
- ☐ At non-designated DOT site
- ☐ Other, specify:_____

C9c. Treatment start date: ___/___/____ ☐ Start date unknown

C9d. Treatment end date: ___/___/____ ☐ End date unknown

C9e. Report of treatment administered prior to panel physician examination:

- ☐ Treatment documented on overseas medical history form (DS 3026)
- ☐ Documented on DS forms & patient reported at panel physician examination
- ☐ After U.S. arrival only, patient verbally reported treatment completion
- ☐ Unknown

C9f. Standard TB treatment regimen was administered?

☐ Yes ☐ No ☐ Unable to verify

C10a. Arrived to the U.S. on treatment?

☐ Yes ☐ No ☐ Unknown

*If **YES,** C10b.* ☐ Treated for TB disease ☐ Treated for LTBI

C10c. Start date: ___/___/____ ☐ Start date unknown

C11a: Pre-Immigration treatment concerns?

☐ Yes ☐ No

*If **YES**, C11b. Select all that apply:*

- ☐ Treatment duration too short
- ☐ Incorrect treatment regimen
- ☐ Inadequate information provided
- ☐ Lack of adequate diagnostics
- ☐ Unknown DOT/adherence status
- ☐ Other, please specify: _____

C12. U.S. Microscopy/Bacteriology* Sputa collected in U.S.? ☐ Yes ☐ No **Covers all results regardless of sputa collection method.*

#	Date Collected	AFB Smear	Sputum Culture	Drug Susceptibility Testing
1	___/___/_____	☐ Positive ☐ Negative ☐ Not Done ☐ Unknown	☐ NTM ☐ MTB Complex ☐ Contaminated ☐ Negative ☐ Not Done ☐ Unknown	☐ MDR-TB ☐ Mono-RIF ☐ Mono-INH ☐ Other DR ☐ No DR ☐ Not Done
2	___/___/_____	☐ Positive ☐ Negative ☐ Not Done ☐ Unknown	☐ NTM ☐ MTB Complex ☐ Contaminated ☐ Negative ☐ Not Done ☐ Unknown	☐ MDR-TB ☐ Mono-RIF ☐ Mono-INH ☐ Other DR ☐ No DR ☐ Not Done
3	___/___/_____	☐ Positive ☐ Negative ☐ Not Done ☐ Unknown	☐ NTM ☐ MTB Complex ☐ Contaminated ☐ Negative ☐ Not Done ☐ Unknown	☐ MDR-TB ☐ Mono-RIF ☐ Mono-INH ☐ Other DR ☐ No DR ☐ Not Done

D. Evaluation Disposition in U.S.

D1a. Evaluation disposition date in U.S.: ___/____/_____

D1b. State/jurisdiction of evaluation disposition in U.S.: _____

D2a. Evaluation disposition in U.S.:

☐ Completed evaluation ☐ Initiated Evaluation / Not completed ☐ Did not initate evaluation

D2b. *If evaluation was completed, was treatment recommended?*

☐ Yes ☐ No

- ☐ LTBI
- ☐ Active TB

D2c. *If evaluation was NOT completed, why not? Select all that apply.*

- ☐ Not Located
- ☐ Lost to Follow-Up
- ☐ Refused Evaluation
- ☐ Unknown
- ☐ Moved within U.S., transferred to:_____ State/jurisdiction
- ☐ Moved outside U.S.
- ☐ Died
- ☐ Other, specify: _____

D3. Diagnosis

- ☐ Class 0 - No TB exposure, not infected or Class 1 - TB exposure, no evidence of infection
- ☐ Class 2 - TB infection, no disease
- ☐ Class 3 - TB, TB disease
  - ☐ Pulmonary ☐ Extra-pulmonary ☐ Both sites
- ☐ Class 4 - TB, inactive disease

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Alien # _____

D4. *If diagnosed with TB disease:*

State Case Number: ☐☐☐☐ ____ _____

Year State RVCT # / TBLISS #

☐ RVCT # unknown* ☐ RVCT Reported*

☐ TBLISS # unknown* ☐ TBLISS Reported*

City/County Case Number: ☐☐☐☐ ____ _____

Year State RVCT # / TBLISS #

*Note: Either the RVCT or TBLISS number may be reported.

E. U.S. Treatment for TB Disease or TB Infection

E1a. U.S. treatment initiated: ☐ Yes ☐ No ☐ Unknown

E1b. *If **NO**, specify the reason. Select all that apply:*

☐ Patient declined against medical advice
☐ Died
☐ Currently on treatment
☐ Contraindication for treatment
☐ Lost to follow-up
☐ Moved outside the U.S.
☐ Treatment not offered based on local clinic guidelines
☐ Moved within U.S., transferred to:_____ State/jurisdiction
☐ Prior treatment completed (year: _____)
☐ Unknown
☐ Other, specify:_____

E1c. *If **YES**:* ☐ Treated for TB disease ☐ Treated for LTBI

E2. Treatment start date: ___/____/_____ E3. State/jurisdiction of treatment in U.S.: _____

E4. Specify initial LTBI regimen:

☐ Isoniazid (9 months; 9H)
☐ Isoniazid (6 months; 6H)
☐ Isoniazid/Rifapentine (3 months; 3HP)
☐ Isoniazid/Rifampin (INH+RIF; 4 months)
☐ Rifampin (4 months; 4R)
☐ Isoniazid/Rifampin/Ethambutol/Pyrazinamide (RIPE; 2 months; suspected TB disease)
☐ Unknown
☐ Other, specify: _____

E5a. U.S. treatment completed: ☐ Yes ☐ No ☐ Unknown

*If **NO**,* E5b. *Specify the reason. Select all that apply:*

☐ Patient declined against medical advice
☐ Died
☐ Dying (treatment stopped because of imminent death, regardless of cause of death)
☐ Provider decision
☐ Lost to follow-up
☐ Moved outside the U.S.
☐ Adverse effect
☐ Not TB disease
☐ Pregnancy [For patient diagnosed with LTBI]
☐ Moved within U.S., transferred to:_____ State/ jurisdiction
☐ Unknown
☐ Other, specify: _____
☐ Developed TB [For patient diagnosed with LTBI]

E6. Date therapy stopped: _____/_____/_____

Specify reason therapy stopped:_____

F. Evaluation Site Information

Provider's Name:

Clinic Name:

Telephone Number:

G. Treatment Site Information

Provider's Name:

Clinic Name:

Telephone Number:

☐ Same as evaluation site information

H. Comments