State of California—Health and Human Services Agency

Print Clear

California Department of Public Health

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

Street Address _____ (ZIP CODE)

REPORT OF VERIFIED CASE OF TUBERCULOSIS

CDPH

REPORT OF VERIFIED CASE OF TUBERCULOSIS

1. Date Reported
Month Day Year

2. Date Submitted
Month Day Year

3. Case Numbers

	Year Reported (YYYY)	State Code	Locally Assigned Identification Number	Reason:
State Case Number				
City/County Case Number				
Linking State Case Number				
Linking State Case Number				

4. Reporting Address for Case Counting

City

Within City Limits *(select one)* ☐ Yes ☐ No

County

ZIP CODE —

5. Count Status *(select one)*

Countable TB Case

☐ Count as a TB case in your jurisdiction

Noncountable TB Case

☐ Verified Case: Counted by another U.S. area (state)

☐ Verified Case: TB treatment initiated in another country *Specify*_____

☐ Verified Case: Recurrent TB within 12 months after completion of therapy

6. Date Counted
Month Day Year

7. Previous Diagnosis of TB Disease *(select one)*

☐ Yes ☐ No

If YES, enter year of previous TB disease diagnosis:

8. Date of Birth
Month Day Year

9. Sex at Birth *(select one)*

☐ Male ☐ Female

10. Ethnicity *(select one)*

☐ Hispanic or Latino

☐ Not Hispanic or Latino

11. Race *(select one or more)*

☐ American Indian or Alaska Native

☐ Asian: *Specify*_____

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander: *Specify*_____

☐ White

12. Country of Birth

"U.S.-born" (or born abroad to a parent who was a U.S. citizen) *(select one)* ☐ Yes ☐ No

Country of birth: *Specify*_____

13. Month-Year Arrived in U.S.
Month Year

14. Pediatric TB Patients (<15 years old)

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

Guardian 1_____

Guardian 2_____

Patient lived outside U.S. for >2 months? *(select one)* ☐ Yes ☐ No ☐ Unknown

If YES, list countries, *specify*: _____

15. Status at TB Diagnosis *(select one)*

☐ Alive ☐ Dead

If DEAD, enter date of death: Month Day Year

If DEAD, was death related to TB disease? *(select one)*

☐ Yes ☐ No ☐ Unknown

16. Site of TB Disease *(select all that apply)*

☐ Pulmonary
☐ Pleural
☐ Lymphatic: Cervical
☐ Lymphatic: Intrathoracic
☐ Lymphatic: Axillary
☐ Lymphatic: Other
☐ Lymphatic: Unknown
☐ Laryngeal
☐ Bone and/or Joint
☐ Genitourinary
☐ Meningeal
☐ Peritoneal
☐ Other: Enter anatomic code(s) *(see list):* 1 2 3
☐ Site not stated

Public reporting burden of this collection of information is estimated to average 35 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 CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, CA 30333, ATTN: PRA (0920-0026). Do not send the completed form to this address.

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

17. Sputum Smear *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown

Date Collected: Month Day Year

18. Sputum Culture *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown

Date Collected: Month Day Year

Date Result Reported: Month Day Year

Reporting Laboratory Type *(select one)*: ☐ Public Health Laboratory ☐ Commercial Laboratory ☐ Other

19. Smear/Pathology/Cytology of Tissue and Other Body Fluids *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown

Date Collected: Month Day Year

Enter anatomic code *(see list)*:

Type of exam *(select all that apply)*: ☐ Smear ☐ Pathology/Cytology

20. Culture of Tissue and Other Body Fluids *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown

Date Collected: Month Day Year

Enter anatomic code *(see list)*:

Date Result Reported: Month Day Year

Reporting Laboratory Type *(select one)*: ☐ Public Health Laboratory ☐ Commercial Laboratory ☐ Other

21. Nucleic Acid Amplification Test Result *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown
☐ Indeterminate

Date Collected: Month Day Year

Date Result Reported: Month Day Year

Enter specimen type: ☐ Sputum
OR
If not Sputum, enter anatomic code *(see list)*:

Reporting Laboratory Type *(select one)*: ☐ Public Health Laboratory ☐ Commercial Laboratory ☐ Other

Initial Chest Radiograph and Other Chest Imaging Study

Cavity Reset Miliary Reset

22A. Initial Chest Radiograph *(select one)*

☐ Normal ☐ Abnormal* (consistent with TB) ☐ Not Done ☐ Unknown

* For ABNORMAL Initial Chest Radiograph: Evidence of a cavity *(select one)*: ☐ Yes ☐ No ☐ Unknown

Evidence of miliary TB *(select one)*: ☐ Yes ☐ No ☐ Unknown

22B. Initial Chest CT Scan or Other Chest Imaging Study *(select one)*

☐ Normal ☐ Abnormal* (consistent with TB) ☐ Not Done ☐ Unknown

Cavity Reset Miliary Reset

* For ABNORMAL Initial Chest Radiograph: Evidence of a cavity *(select one)*: ☐ Yes ☐ No ☐ Unknown

Evidence of miliary TB *(select one)*: ☐ Yes ☐ No ☐ Unknown

23. Tuberculin (Mantoux) Skin Test at Diagnosis *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown

Date Tuberculin Skin Test (TST) Placed: Month Day Year

Millimeters (mm) of induration:

24. Interferon Gamma Release Assay for *Mycobacterium tuberculosis* at Diagnosis *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown
☐ Indeterminate

Date Collected: Month Day Year

Test type:
*Specify*_____

25. Primary Reason Evaluated for TB Disease *(select one)*

☐ TB Symptoms
☐ Abnormal Chest Radiograph (consistent with TB)
☐ Contact Investigation
☐ Targeted Testing
☐ Health Care Worker
☐ Employment/Administrative Testing
☐ Immigration Medical Exam
☐ Incidental Lab Result
☐ Unknown

REPORT OF VERIFIED CASE OF TUBERCULOSIS

26. HIV Status at Time of Diagnosis *(select one)*

☐ Negative ☐ Indeterminate ☐ Not Offered ☐ Unknown
☐ Positive ☐ Refused ☐ Test Done, Results Unknown

If POSITIVE, enter:
State HIV/AIDS Patient Number: | | | | | | | | | | |
City/County HIV/AIDS Patient Number: | | | | | | | | | | |

27. Homeless Within Past Year *(select one)*

☐ No ☐ Yes ☐ Unknown

28. Resident of Correctional Facility at Time of Diagnosis *(select one)* ☐ No ☐ Yes ☐ Unknown

If YES, *(select one)*

☐ Federal Prison ☐ Local Jail ☐ Other Correctional Facility
☐ State Prison ☐ Juvenile Correction Facility ☐ Unknown

If YES, under custody of Immigration and Customs Enforcement? *(select one)*

☐ No ☐ Yes

29. Resident of Long-Term Care Facility at Time of Diagnosis *(select one)* ☐ No ☐ Yes ☐ Unknown

If YES, *(select one)*

☐ Nursing Home ☐ Residential Facility ☐ Alcohol or Drug Treatment Facility ☐ Unknown
☐ Hospital-Based Facility ☐ Mental Health Residential Facility ☐ Other Long-Term Care Facility

30. Primary Occupation Within the Past Year *(select one)*

☐ Health Care Worker ☐ Migrant/Seasonal Worker ☐ Retired ☐ Not Seeking Employment (e.g. student, homemaker, disabled person)
☐ Correctional Facility Employee ☐ Other Occupation ☐ Unemployed ☐ Unknown

31. Injecting Drug Use Within Past Year *(select one)*

☐ No ☐ Yes ☐ Unknown

32. Non-Injecting Drug Use Within Past Year *(select one)*

☐ No ☐ Yes ☐ Unknown

33. Excess Alcohol Use Within Past Year *(select one)*

☐ No ☐ Yes ☐ Unknown

34. Additional TB Risk Factors *(select all that apply)*

☐ Contact of MDR-TB Patient (2 years or less) ☐ Incomplete LTBI Therapy ☐ Diabetes Mellitus ☐ Other *Specify* _____
☐ Contact of Infectious TB Patient (2 years or less) ☐ TNF-α Antagonist Therapy ☐ End-Stage Renal Disease ☐ None
☐ Missed Contact (2 years or less) ☐ Post-organ Transplantation ☐ Immunosuppression (not HIV/AIDS)

35. Immigration Status at First Entry to the U.S. *(select one)*

☐ Not Applicable
- "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

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

35CA. If arrived in the US within the last 12 months, did patient arrive with a TB A/B-notification? *(select one)* ☐ No ☐ Yes ☐ Unknown

If Yes, enter Alien Number: | | | | | | | | | |

36. Date Therapy Started

Month | | Day | | Year | | | |

37. Initial Drug Regimen *(select one option for each drug)*

	No	Yes	Unk		No	Yes	Unk		No	Yes	Unk
Isoniazid	☐	☐	☐	Ethionamide	☐	☐	☐	Moxifloxacin	☐	☐	☐
Rifampin	☐	☐	☐	Amikacin	☐	☐	☐	Cycloserine	☐	☐	☐
Pyrazinamide	☐	☐	☐	Kanamycin	☐	☐	☐	Para-Amino Salicylic Acid	☐	☐	☐
Ethambutol	☐	☐	☐	Capreomycin	☐	☐	☐	Other	☐	☐	☐
Streptomycin	☐	☐	☐	Ciprofloxacin	☐	☐	☐	*Specify* _____			
Rifabutin	☐	☐	☐	Levofloxacin	☐	☐	☐	Other	☐	☐	☐
Rifapentine	☐	☐	☐	Ofloxacin	☐	☐	☐	*Specify* _____			

Comments: