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

Case Completion Report

(Follow Up Report – 2)

Year Counted ☐☐☐☐

State Case Number ☐☐☐☐ ☐☐ ☐☐☐☐☐☐☐☐☐

City/County Case Number ☐☐☐☐ ☐☐ ☐☐☐☐☐☐☐☐☐

Submit this report for all cases in which the patient was alive at diagnosis.

41. Sputum Culture Conversion Documented *(select one)* ☐ No ☐ Yes ☐ Unknown

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

Month ☐☐ Day ☐☐ Year ☐☐☐☐

If NO, enter reason for not documenting sputum culture conversion *(select one)*:

☐ No Follow-up Sputum Despite Induction
☐ Patient Refused
☐ Patient Lost to Follow-Up
☐ No Follow-up Sputum and No Induction
☐ Other *Specify* _____
☐ Died
☐ Unknown

42. Moved

Did the patient move before starting or during TB therapy? *(select one)* ☐ No ☐ Yes

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

☐ In state, out of jurisdiction *(enter city/county)*: *Specify* _____ Date Patient Received _____
Specify _____ Date Patient Received _____
Specify _____ Date Patient Received _____

☐ Out of state *(enter state)*: *Specify* _____ Date Patient Received _____
Specify _____ Date Patient Received _____
Specify _____ Date Patient Received _____

☐ Out of the U.S. *(enter country)*: *Specify* _____ Date Patient Received _____
Specify _____ Date Patient Received _____

If moved out of the U.S., transnational referral? *(select one)* ☐ No ☐ Yes **Referral Reset**

43. Date Therapy Stopped

Month ☐☐ Day ☐☐ Year ☐☐☐☐

44. Reason Therapy Stopped or Never Started *(select one)*

☐ Completed Therapy
☐ Not TB
☐ Lost
☐ Died
☐ Uncooperative or Refused
☐ Other
☐ Adverse Treatment Event
☐ Unknown

If DIED, indicate cause of death *(select one)*:

☐ Related to TB disease
☐ Unrelated to TB disease
☐ Related to TB therapy
☐ Unknown

45. Reason Therapy Extended >12 months *(select all that apply)*

☐ Rifampin Resistance
☐ Non-adherence
☐ Clinically Indicated - other reasons
☐ Adverse Drug Reaction
☐ Failure
☐ Other *Specify* _____

46. Type of Outpatient Health Care Provider *(select all that apply)*

☐ Local/State Health Department (HD)
☐ IHS, Tribal HD, or Tribal Corporation
☐ Inpatient Care Only
☐ Unknown
☐ Private Outpatient
☐ Institutional/Correctional
☐ Other

Comments:

Patient's Name _____ **State Case No.** _____
(Last) (First) (M.I.)

REPORT OF VERIFIED CASE OF TUBERCULOSIS

Case Completion Report - *Continued*

(Follow Up Report – 2)

47. Directly Observed Therapy (DOT) *(select one)*

☐ No, Totally Self-Administered

☐ Yes, Totally Directly Observed

☐ Yes, Both Directly Observed and Self-Administered

☐ Unknown

Number of weeks of directly observed therapy (DOT) ☐☐☐

48. Final Drug Susceptibility Testing

Was follow-up drug susceptibility testing done? *(select one)* ☐ No ☐ Yes ☐ Unknown

If NO or UNKNOWN, do not complete the rest of Follow Up Report – 2

If YES, enter date FINAL isolate collected for which drug susceptibility testing was done:

Month ☐☐ Day ☐☐ Year ☐☐☐☐

Enter specimen type: ☐ Sputum

OR

If not Sputum, enter anatomic code *(see list)*: ☐☐

49. Final Drug Susceptibility Results *(select one option for each drug)*

	Resistant	Susceptible	Not Done	Unknown
Isoniazid	☐	☐	☐	☐
Rifampin	☐	☐	☐	☐
Pyrazinamide	☐	☐	☐	☐
Ethambutol	☐	☐	☐	☐
Streptomycin	☐	☐	☐	☐
Rifabutin	☐	☐	☐	☐
Rifapentine	☐	☐	☐	☐
Ethionamide	☐	☐	☐	☐
Amikacin	☐	☐	☐	☐
Kanamycin	☐	☐	☐	☐

	Resistant	Susceptible	Not Done	Unknown
Capreomycin	☐	☐	☐	☐
Ciprofloxacin	☐	☐	☐	☐
Levofloxacin	☐	☐	☐	☐
Ofloxacin	☐	☐	☐	☐
Moxifloxacin	☐	☐	☐	☐
Other Quinolones	☐	☐	☐	☐
Cycloserine	☐	☐	☐	☐
Para-Amino Salicylic Acid	☐	☐	☐	☐
Other	☐	☐	☐	☐
Specify _____				
Other	☐	☐	☐	☐
Specify _____				

Comments: