| Patient's Name _ |        |                               |        |  |            | REPORT OF VERIFIED CASE |
|------------------|--------|-------------------------------|--------|--|------------|-------------------------|
|                  | (Last) | (First)                       | (M.I.) |  |            | OFTUBERCULOSIS          |
| Street Address _ |        |                               |        |  |            | 0. 1022.100200.0        |
|                  |        | (Number, Street, City, State) |        |  | (ZIP CODE) |                         |
|                  |        |                               |        |  |            |                         |



| Case Completion   | neport   |   |   | (Follow Up Report – 2 |
|---|--|---|---|-----------------------|
| Year Counted  | State<br>Case Number                                 |   |   |                       |
|   | City/County<br>Case Number                           |   |   |                       |
| -   |  | in which the patient was  | alive at diagnosis.   |                       |
| 41. Sputum Culture Cor  | nversion Documented                                  | (select one) No Yes   | Unknown   |                       |
| If YES, enter date speconsistently negative s                   | ccimen collected for FIRS<br>sputum culture:<br>Year | If NO, enter reason for not docu  No Follow-up Sputum Despite Induction No Follow-up Sputum and N | umenting sputum culture conversion (substitution Patient Refused  No Induction Other Specify —  Unknown | (select one):         |
| 42. Moved   |  |   | <u> </u>  |                       |
| Did the patient move b  | re (select all that apply)                           | TB therapy? (select one) No Specify   |   |                       |
| Out of state (enter s   |  | Specify<br>Specify<br>Specify   | Date Patient Received Date Patient Received Date Patient Received                                       | ede                   |
| Out of the U.S. (ent  | ter country) S., transnational referral              | Specify Specify Specify Specify (select one) No Ye  | Date Patient Received Date Patient Received   | ede                   |
| 43. Date Therapy Stoppe   |  | 44. Reason Therapy Stopped or   |   |                       |
| Month Day   | Year   | Completed Therapy  Lost Uncooperative or Refuse  Adverse Treatment Event                          | Died Related to T   |                       |
| 45. Reason Therapy Exte   | ended >12 months (se                                 | ect all that apply)   |   |                       |
| Rifampin Resistand  |  | Non-adherence   | Clinically Indicated - other rea  | asons                 |
| Adverse Drug Rea  | ction  | Failure   | Other Specify   |                       |
| 46. Type of Outpatient He Local/State Health Private Outpatient | Department (HD)                                      | elect all that apply)  IHS, Tribal HD, or Tribal Corporatio  Institutional/Correctional           | on Inpatient Care Only Other  | Unknown               |
| Comments:   |  |   |   |                       |
|   |  |   |   |                       |
|   |  |   |   |                       |

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 **OFTUBERCULOSIS** 

| Patient's Name |        |         | State Case No. |  |
|----------------|--------|---------|----------------|--|
|                | (Last) | (First) | (M I)          |  |



## REPORT OF VERIFIED CASE OF TUBERCULOSIS

| Case Completion Rep  | ort - Continu          | iea                 |                           |                   | (F             | ollow U      | Jp Report – 2  |  |
|--|------------------------|---------------------|---------------------------|-------------------|----------------|--------------|----------------|--|
| 47. Directly Observed Therapy (  | DOT) (select one)      |                     |                           |                   |                |              |                |  |
| ☐ No, Totally Self-Administer  | ed                     |                     |                           |                   |                |              |                |  |
| 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 susceptib   | ility testing done? (s | select one) No      | Yes Unknown               |                   |                |              |                |  |
| If NO or UNKNOWN, do n   | ot complete the re     | st of Follow Up Rei | oort – 2                  |                   |                |              |                |  |
| 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                   |                     |                           | OR If not Sputum, | enter anaton   | nic code (se | e list):       |  |
|  |                        |                     |                           | п пос орашт,      | , enter anaton | inc code (3e | e list).       |  |
| 49. Final Drug Susceptibility Results (select one option for each drug)  |                        |                     |                           |                   |                |              |                |  |
| Resis  | stant Susceptible      | Not Done Unknown    |                           | Resistant         | Susceptible    | Not Done     | <u>Unknown</u> |  |
| Isoniazid  |                        |                     | Capreomycin               |                   |                |              |                |  |
| Rifampin   |                        |                     | Ciprofloxacin             |                   |                |              |                |  |
| Pyrazinamide   |                        |                     | Levofloxacin              |                   |                |              |                |  |
| Ethambutol   |                        |                     | Ofloxacin                 |                   |                |              |                |  |
| Streptomycin   |                        |                     | Moxifloxacin              |                   |                |              |                |  |
| Rifabutin  |                        |                     | Other Quinolones          |                   |                |              |                |  |
| Rifapentine  |                        |                     | Cycloserine               |                   |                |              |                |  |
| Ethionamide  |                        |                     | Para-Amino Salicylic Acid |                   |                |              |                |  |
| Amikacin   |                        |                     | Other                     |                   |                |              |                |  |
| Kanamycin  |                        |                     | Specify                   |                   |                |              |                |  |
|  |                        |                     | Other                     |                   |                |              |                |  |
|  |                        |                     | Specify                   |                   |                |              |                |  |
| Comments:  |                        |                     |                           |                   |                |              |                |  |
|  |                        |                     |                           |                   |                |              |                |  |
|  |                        |                     |                           |                   |                |              |                |  |
|  |                        |                     |                           |                   |                |              |                |  |
|  |                        |                     |                           |                   |                |              |                |  |
|  |                        |                     |                           |                   |                |              |                |  |
|  |                        |                     |                           |                   |                |              |                |  |
|  |                        |                     |                           |                   |                |              |                |  |
|  |                        |                     |                           |                   |                |              |                |  |

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