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Report of Suspect/Verified Case of Tuberculosis (RVCT)

Michigan Department of Community Health

Communicable Disease Division

Investigation Information

Investigation ID	Onset Date mm/dd/yyyy	Diagnosis Date mm/dd/yyyy	Referral Date mm/dd/yyyy	Case Entry Date mm/dd/yyyy	Case Completion Date mm/dd/yyyy

State TB Case No (State Use Only)	Investigation Status

Case Status

○ *Confirmed* ○ *Confirmed - Non Resident* ○ *Not a Case* ○ *Probable* ○ *Suspect* ○ *Unknown*

Patient Status	Patient Status Date mm/dd/yyyy	Part of an outbreak?	Outbreak Name	Case Updated Date mm/dd/yyyy

Patient Information

Patient ID	First	Last	Middle

Street Address	Within City Limits?
	○ *Yes* ○ *No* ○ *Unknown*

City	County	State	Zip

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.

Parent/Guardian (required if under 18)

First	Last	Middle

Demographics

Sex	Date of Birth mm/dd/yyyy	Age	Age Units
○ *Male* ○ *Female* ○ *Unknown*			○ *Days* ○ *Months* ○ *Years*

Race (Check all that apply)

☐ *Caucasian* ☐ *African American* ☐ *American Indian/Alaska Native* ☐ *Hawaiian/Pacific Islander*
☐ *Asian* ☐ *Unknown* ☐ *Other (Specify)*_____

Hispanic Ethnicity	Arab Ethnicity
○ *Hispanic /Latino* ○ *Non-Hispanic/Latino* ○ *Unknown*	○ *Arab* ○ *Non-Arab* ○ *Unknown*

Worksites/School	Occupation/Grade

Referral Information

Person Providing Referral

First	Last	Phone ###-###-####	Ext.	Email

Referral Information cont.

Primary Physician

First	Last	Phone ###-###-####	Ext.	Email

Street Address

City	County	State	Zip

Additional Surveillance Information

Count Status

○ *Count as a TB Case* ○ *Verified Case: Counted by another US area*
○ *Verified Case: TB treatment in other country* ○ *Verfied Case: Recurrent TB w/in 12 months*

Specify Other Country

Case Links

Linking State Case Number	Reason
	Epi link, Recurrence, Transfer

Clinical Information

Primary Reason Evaluated for TB Disease

○ *TB Symptoms* ○ *Abnormal Chest Radiograph* ○ *Contact Investigation* ○ *Immigration Medical Exam* ○ *Targeted Testing*
○ *Health Care Worker* ○ *Employment/administrative Testing* ○ *Incidental Lab Result* ○ *Unknown*

Verification Criteria (select one)

○ *Positive Culture* ○ *Positive Smear/tissue* ○ *Clinical Case* ○ *Provider Diagnosis* ○ *Not a Verified Case*

Date Counted mm/dd/yyyy (State Use Only)

Previous Diagnosis of Tuberculosis

○ *Yes* ○ *No* ○ *Unknown*

If yes, list year of previous diagnosis

Site of TB Disease (select all that apply)

☐ *Pulmonary* ☐ *Pleural* ☐ *Lymphatic: Cervical* ☐ *Lymphatic: Intrathoracic*
☐ *Laryngeal* ☐ *Lymphatic: Axillary* ☐ *Lymphatic: Other*_____ ☐ *Lymphatic: Unknown*
☐ *Bone and/or Joint* ☐ *Genitourinary* ☐ *Meningeal* ☐ *Peritoneal*
☐ *Other*_____ ☐ *Site Not Stated*

Other Sites of TB Disease (1)

Other Sites of TB Disease (2)

Other Sites of TB Disease (3)

Status at Diagnosis of TB

○ *Alive* ○ *Dead*

If Dead, was TB a cause of death?

○ *No* ○ *Yes* ○ *Unknown*

If Dead, enter date of death mm/dd/yyyy

Laboratory Information

Sputum Smear

○ *Positive* ○ *Negative* ○ *Not Done* ○ *Unknown*

Sputum Smear Collection Date mm/dd/yyyy

Sputum Culture

○ *Positive* ○ *Negative* ○ *Not Done* ○ *Unknown*

Smear/Pathology/Cytology of Tissue and Other Body Fluids

○ *Positive* ○ *Negative* ○ *Not Done* ○ *Unknown*

Sputum Culture Collection Date mm/dd/yyyy	Sputum Culture Report Date mm/dd/yyyy	Smear/Pathology/Cytology Collection Date mm/dd/yyyy

Laboratory Information cont.

If positive specimen, enter anatomic code

Type of Exam
(Check all that apply)
☐ *Smear* ☐ *Pathology/Cytology*

Culture of Tissue and Other Body Fluids
○ *Positive* ○ *Negative* ○ *Not Done* ○ *Unknown*

Culture of Tissue and Other Body Fluids Collection Date
mm/dd/yyyy

If culture is positive, enter anatomic code

Nucleic Acid Amplification Test Result
○ *Positive* ○ *Negative* ○ *Not Done* ○ *Indeterminate* ○ *Unknown*

Nucleic Acid Amplification Test Result Collection Date
mm/dd/yyyy

Indicate if specimen type for the NAA testing is Sputum
○ *Yes* ○ *No*

If not Sputum, enter anatomic code

Nucleic Acid Amplification Report Date
mm/dd/yyyy

NAA Reporting Laboratory Type
○ *Public Health Laboratory* ○ *Commercial Laboratory* ○ *Other*_____

Initial Chest Radiograph
○ *Normal* ○ *Abnormal* ○ *Not Done* ○ *Unknown*

For Abnormal Initial Chest Radiograph: Evidence of a cavity
○ *Yes* ○ *No* ○ *Unknown*

For Abnormal Initial Chest Radiograph: Evidence of miliary TB
○ *Yes* ○ *No* ○ *Unknown*

Initial Chest CT Scan or Other Chest Imaging Study
○ *Normal* ○ *Abnormal* ○ *Not Done* ○ *Unknown*

For Abnormal Chest CT Scan: Evidence of a cavity
○ *Yes* ○ *No* ○ *Unknown*

For Abnormal Chest CT Scan: Evidence of miliary TB
○ *Yes* ○ *No* ○ *Unknown*

Tuberculin (Mantoux) Skin Test at Diagnosis
○ *Positive* ○ *Negative* ○ *Not Done* ○ *Unknown*

TST Placement Date
mm/dd/yyyy

TST Read Date
mm/dd/yyyy

Millimeters (mm) of induration

Previously Positive TST
○ *Yes* ○ *No* ○ *Unknown*

Date of Previously Positive TST
mm/dd/yyyy

Interferon Gamma Release Assay for Mycobacterium tuberculosis at Diagnosis
○ *Positive* ○ *Negative* ○ *Indeterminate* ○ *Not Done* ○ *Unknown*

Interferon Gamma Release Assay: Type of Test
(Check all that apply)
☐ *QuantiFERON-TB Test* ☐ *T-SPOT.TB Test*

Interferon Gamma Release Assay Collection Date
mm/dd/yyyy

Epidemiologic Information

Country of Birth

Month-Year Arrived in the U.S.
mm/yyyy (if country of birth other than U.S.)

Immigration Status
○ *Not Applicable/U.S.-born* ○ *Immigrant Visa* ○ *Student Visa "F", "M", "J"* ○ *Asylee or Parolee*
○ *Other Immigration Status*_____ ○ *Tourist Visa "B"* ○ *Employment Visa "H", "E", "L", "J"* ○ *"V" Visa or "K" Visa*
○ *Refugee* ○ *Unknown*

Pediatric TB Patients (<15 years old)

Patient Lived outside U.S. for > 2 months?
○ *No* ○ *Yes* ○ *Unknown*

If Yes, enter country (1)

If Yes, enter country (2)

If Yes, enter country (3)

Country of Birth for Primary Guardian 1

Country of Birth for Primary Guardian 2

Epidemiologic Information cont.

HIV Information

HIV Status

○ *Negative* ○ *Positive* ○ *Indeterminate* ○ *Refused* ○ *Not Offered* ○ *Test Done, Results Unknown* ○ *Unknown*

If Positive, State HIV/AIDS Patient Number
(If AIDS Reported 1993 or Later)

If Positive, City/County HIV/AIDS Patient Number
(If AIDS Reported 1993 or Later)

Other Information

Homeless Within Past Year?
○ *No* ○ *Yes* ○ *Unknown*

Resident of Correctional Facility at Time of Diagnosis?
○ *No* ○ *Yes* ○ *Unknown*

If yes, specify type of correctional facility at time of diagnosis:

○ *Federal Prison* ○ *State Prison* ○ *Local Jail* ○ *Juvenile Correctional Facility*
○ *ICE (former INS) Detention* ○ *Other Correctional Facility*_____ ○ *Unknown*

Resident of Long-Term Care Facility at Time of Diagnosis?
○ *No* ○ *Yes* ○ *Unknown*

If yes, specify type of long-term care facility at time of diagnosis:

○ *Nursing Home* ○ *Hospital-Based facility* ○ *Residential Facility*
○ *Mental Health Residential Facility* ○ *Alcohol or Drug Treatment Facility* ○ *Other Long-Term Care Facility*_____
○ *Unknown*

Injecting Drug Use Within Past Year
○ *No* ○ *Yes* ○ *Unknown*

Non-Injecting Drug Use Within Past Year
○ *No* ○ *Yes* ○ *Unknown*

Excess Alcohol Use Within Past Year
○ *No* ○ *Yes* ○ *Unknown*

Occupation Within the Past 24 Months
* Other (e.g. child, student, retiree, institutionalized person)

☐ *Employed* ☐ *Unemployed* ☐ *Unknown* ☐ *Other**_____

If Employed:
(select all that apply)

☐ *Health Care Worker* ☐ *Correctional Facility Employee* ☐ *Migrant/Seasonal Worker* ☐ *Other Occupation*_____

Additional TB Risk Factors
(select all that apply)

☐ *Contact of Infectious TB Patient* ☐ *Contact of MDR-TB Patient* ☐ *Contact of XDR-TB Patient* ☐ *Missed Contact*
☐ *Incomplete LTBI Treatment* ☐ *Diabetes Mellitus* ☐ *End-Stage Renal Disease* ☐ *Post-organ Transplantation*
☐ *TNF-a Antagonist Therapy* ☐ *Immunosuppression (not HIV/AIDS)* ☐ *Other*_____ ☐ *Unknown*

Treatment Information

Date Therapy Started mm/dd/yyyy	**Directly Observed Therapy (DOT)** ○ *Yes* ○ *No* ○ *Unknown*	**If Yes, DOT Start Date** mm/dd/yyyy

Drug	Part of Regimen	Dosage	Frequency
	0=No 1=Yes 9=Unknown	(mg)	1=7x/week 2=5x/week 3=3x/week 4=2x/week
ISONIAZID			
RIFAMPIN			
PYRAZINAMIDE			
ETHAMBUTOL			
RIFABUTIN			
RIFAPENTINE			
ETHIONAMIDE			
STREPTOMYCIN			
AMIKACIN			
KANAMYCIN			
CAPREOMYCIN			
CIPROFLOXACIN			
LEVOFLOXACIN			
OFLOXACIN			
MOXIFLOXACIN			
CYCLOSERINE			
PARA-AMINO SALICYLIC ACID			
OTHER 1			
OTHER 2			

Specify OTHER 1	**Specify OTHER 2**

Follow Up Report -- 1: Initial Drug Susceptibility Report (State Use Only)

Was Drug Susceptibility Testing Done? ○ *No* ○ *Yes* ○ *Unknown*	**If Yes, Specimen Collection Date**

Drug Susceptibility Report Completed? ○ *Yes* ○ *No* ○ *Unknown*

If Yes, Enter Specimen Type	**If not Sputum, enter Anatomic Code**

Drug	Result
	1=Resistant 2=Susceptible 3=Not Done 9=Unknown
ISONIAZID	
RIFAMPIN	
PYRAZINAMIDE	
ETHAMBUTOL	
RIFABUTIN	
RIFAPENTINE	
ETHIONAMIDE	
STREPTOMYCIN	
AMIKACIN	
KANAMYCIN	
CAPREOMYCIN	
CIPROFLOXACIN	
LEVOFLOXACIN	
MOXIFLOXACIN	
OFLOXACIN	
OTHER QUINOLONES	
CYCLOSERINE	
PARA-AMINO SALICYLIC ACID	
OTHER 1	
OTHER 2	

Specify OTHER 1	**Specify OTHER 2**

Follow Up Report -- 2: Case Completion Report

Case Completion Report Completed?
○ *Yes* ○ *No* ○ *Unknown*

Sputum Culture Conversion Documented
○ *No* ○ *Yes* ○ *Unknown*

If Yes, Date Specimen Collected on First Consistently Negative Culture
mm/dd/yyyy

If No, Reason For Not Documenting Sputum Culture Conversion
○ *Clinically improved: No follow-up sputum despite induction* ○ *No follow-up sputum collected* ○ *No initial sputum result or none collected*
○ *Died* ○ *Patient lost* ○ *Patient refused*
○ *Other*_____ ○ *Unknown*

U.S.-Mexico Binational Status
○ *Binational TB Case* ○ *Not a binational TB case* ○ *Unknown*

If a binational TB case, reason why
(select all that apply)
☐ *Diagnositic/Clinical/Treatment Information Exchange* ☐ *Contacts* ☐ *Laboratory/Radiologic Testing*

Did the patient move during TB therapy
○ *No* ○ *Yes* ○ *Unknown*

If Yes, moved to where
(select all that apply)
☐ *In state, out of jurisdiction* ☐ *Out of state* ☐ *Out of the U.S.*

If moved in state, out of jurisdiction, enter county #1

If moved in state, out of jurisdiction, enter city #1

If moved in state, out of jurisdiction, enter county #2

If moved in state, out of jurisdiction, enter city #2

If moved out of state, enter state #1

If moved out of state, enter state #2

If moved out of the U.S., enter country #1

If moved out of the U.S., enter country #2

If moved out of the US, indicate whether a transnational referral was made
○ *Yes* ○ *No*

Date Therapy Stopped
mm/dd/yyyy

Reason Therapy Stopped or Never Started
○ *Completed Therapy* ○ *Lost* ○ *Uncooperative or Refused* ○ *Adverse Treatment Event*
○ *Not TB* ○ *Died* ○ *Other*_____ ○ *Unknown*

If Died, indicate cause of death
○ *Related to TB disease* ○ *Related to TB therapy* ○ *Unrelated to TB disease* ○ *Unknown*

Reason Therapy Extending >12 months
(select all that apply)
☐ *Rifampin resistance (only)* ☐ *Other drug resistance (non-Rifampin)*_____ ☐ *Adverse drug reaction*
☐ *Non-adherence* ☐ *Failure* ☐ *Clinically indicated - other reasons*
☐ *Other*_____ ☐ *Unknown*

Type of Health Care Provider
(select all that apply)
☐ *Local/State Health Department (HD)* ☐ *Public non-Local/State HD* ☐ *IHS, Tribal HD, or Tribal Corporation* ☐ *Private*
☐ *Institutional* ☐ *No Outpatient Care* ☐ *Other*_____ ☐ *Unknown*

Directly Observed Therapy (DOT)

Number of DOT weeks

Number of self-administered weeks

Number of unknown weeks

Was Follow-up Drug Susceptibility Testing Done?
○ *No* ○ *Yes* ○ *Unknown*

If Yes, Enter Date Final Isolate Collected for Which Drug Susceptibility Was Done
mm/dd/yyyy

If Yes, enter specimen type
○ *Sputum* ○ *Other*_____

If not Sputum, enter Anatomic Code

Isolate submitted for genotyping?
○ *Yes* ○ *No*

Genotype Accession Number for current episode

Follow Up Report -- 2: Case Completion Report cont.

Drug	Result
	1=Resistant 2=Susceptible 3=Not Done 9=Unknown
ISONIAZID	
RIFAMPIN	
PYRAZINAMIDE	
ETHAMBUTOL	
RIFABUTIN	
RIFAPENTINE	
ETHIONAMIDE	
STREPTOMYCIN	
AMIKACIN	
KANAMYCIN	
CAPREOMYCIN	
CIPROFLOXACIN	
LEVOFLOXACIN	
MOXIFLOXACIN	
OFLOXACIN	
OTHER QUINOLONES	
CYCLOSERINE	
PARA-AMINO SALICYLIC ACID	
OTHER 1	
OTHER 2	

Specify OTHER 1	Specify OTHER 2

Contact Information

Name of Contact	Birthdate	Contact Level	Prior Positive PPD	Initial PPD Date	Initial PPD Result	Final PPD Date	Final PPD Result	X Ray Date	X Ray Result
	mm/dd/yyyy	1=Close 2=Casual 3=Remote	1=Yes 2=No 9=Unknown	mm/dd/yyyy	(mm)	mm/dd/yyyy	(mm)	mm/dd/yyyy	

Lab Results

Report Date	Test Name	Test Result	Specimen	Collection Date
mm/dd/yyyy				mm/dd/yyyy

Other Information

Local 1	**Local 2**

Name of Person interviewed	**Relationship to patient**	**Date of interview** mm/dd/yyyy

Submitted by:	**Date** mm/dd/yyyy	**Health Department**	**Phone Number** ###-###-####	**Ext.**

Other Information cont.

Comments or Additional Information

Activate Form | Submit Form | Cancel Form | Case Definitions