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

Street Address: _____ (Number, Street, City, State) Zip Code)

REPORT OF VERIFIED CASE OF TUBERCULOSIS

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

DEPARTMENT OF HEALTH & HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL
AND PREVENTION (CDC)
ATLANTA, GEORGIA 30333

FORM APPROVED OMB NO. 0920-0026 Exp. Date 09/30/2005

REPORT OF VERIFIED CASE OF TUBERCULOSIS

SOUNDEX ☐☐☐☐

1. State Reporting:

Specify: _____

Alpha State Code ☐☐

2.

State Case Number: ☐☐☐☐☐☐☐☐☐

City/County Case Number: ☐☐☐☐☐☐☐☐☐

3. Date Submitted: Mo. ☐☐ Day ☐☐ Yr. ☐☐

By: _____

4. Address for Case Counting:

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Within City Limits 1☐ Yes 2☐ No

County ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Zip Code ☐☐☐☐☐ — ☐☐☐☐

5. Month-Year Reported: Mo. ☐☐ Yr. ☐☐☐☐

6. Month-Year Counted: Mo. ☐☐ Yr. ☐☐☐☐

7. Date of Birth: Mo. ☐☐ Day ☐☐ Yr. ☐☐☐☐

8. Sex:

1☐ Male
2☐ Female

9. Ethnicity: *(Select one)*

1☐ Hispanic or Latino
2☐ Not Hispanic or Latino

10. Race: *(Select one or more)*

1☐ American Indian or Alaska Native
2☐ Asian *Specify (Optional):* _____
3☐ Black or African American
4☐ Native Hawaiian or Other Pacific Islander *Specify (Optional):* _____
5☐ White

11. Country of Origin:

If U.S., check here ☐ If not U.S., enter country code (see list) ☐☐

12. Month-Year Arrived in U.S.: Mo. ☐☐ Yr. ☐☐☐☐

13. Status at Diagnosis of TB:

1☐ Alive 2☐ Dead

14. Previous Diagnosis of Tuberculosis:

1☐ Yes
2☐ No

Yr. ☐☐☐☐ If yes, list year of previous diagnosis

1☐ If more than one previous episode, check here

15. Major Site of Disease:

00☐ Pulmonary
10☐ Pleural
21☐ Lymphatic: Cervical
22☐ Lymphatic: Intrathoracic
23☐ Lymphatic: Other
29☐ Lymphatic: Unknown
30☐ Bone and/or Joint
40☐ Genitourinary
50☐ Miliary
60☐ Meningeal
70☐ Peritoneal
80☐ Other*
90☐ Site not Stated

*If site is "Other", enter anatomic code (see list) ☐☐

16. Additional Site of Disease:

00☐ Pulmonary
10☐ Pleural
21☐ Lymphatic: Cervical
22☐ Lymphatic: Intrathoracic
23☐ Lymphatic: Other
29☐ Lymphatic: Unknown
30☐ Bone and/or Joint
40☐ Genitourinary
50☐ Miliary
60☐ Meningeal
70☐ Peritoneal
80☐ Other*

*If site is "Other", enter anatomic code (see list) ☐☐

If more than one additional site, check here ☐ 88

17. Sputum Smear:

1☐ Positive 3☐ Not Done
2☐ Negative 9☐ Unknown

18. Sputum Culture:

1☐ Positive 3☐ Not Done
2☐ Negative 9☐ Unknown

19. Microscopic Exam of Tissue and Other Body Fluids:

1☐ Positive 3☐ Not Done
2☐ Negative 9☐ Unknown

If positive, enter anatomic code(s) (see list) ☐☐ ☐☐

20. Culture of Tissue and Other Body Fluids:

1☐ Positive 3☐ Not Done
2☐ Negative 9☐ Unknown

If positive, enter anatomic code(s) (see list) ☐☐ ☐☐

21. Chest X-Ray:

1☐ Normal 2☐ Abnormal 3☐ Not Done 9☐ Unknown

If Abnormal *(check one)* 1☐ Cavitary 2☐ Noncavitary Consistent with TB 3☐ Noncavitary Not Consistent with TB

If Abnormal *(check one)* 1☐ Stable 3☐ Improving 2☐ Worsening 9☐ Unknown

22. Tuberculin (Mantoux) Skin Test at Diagnosis:

1☐ Positive 3☐ Not Done
2☐ Negative 9☐ Unknown

Millimeters (mm) of Induration ☐☐

If Negative, was patient anergic? 1☐ Yes 2☐ No 9☐ Unknown

REPORT OF VERIFIED CASE OF TUBERCULOSIS

23. HIV Status: 0 ☐ Negative 3 ☐ Refused 9 ☐ Unknown
1 ☐ Positive 4 ☐ Not Offered
2 ☐ Indeterminate 5 ☐ Test Done, Results Unknown

If Positive, Based on: 1 ☐ Medical Documentation 2 ☐ Patient History 9 ☐ Unknown

If Positive, List: CDC AIDS Patient Number ☐☐☐☐☐☐☐ (If AIDS Reported before 1993)

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

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

24. Homeless Within Past Year:
0 ☐ No
1 ☐ Yes
9 ☐ Unknown

25. Resident of Correctional Facility at Time of Diagnosis: 0 ☐ No 1 ☐ Yes 9 ☐ Unknown

If Yes, 1 ☐ Federal Prison 3 ☐ Local Jail 5 ☐ Other Correctional Facility
2 ☐ State Prison 4 ☐ Juvenile Correctional Facility 9 ☐ Unknown

26. Resident of Long-Term Care Facility at Time of Diagnosis: 0 ☐ No 1 ☐ Yes 9 ☐ Unknown

If Yes, 1 ☐ Nursing Home 4 ☐ Mental Health Residential Facility 6 ☐ Other Long-Term Care Facility
2 ☐ Hospital-Based Facility 5 ☐ Alcohol or Drug Treatment Facility 9 ☐ Unknown
3 ☐ Residential Facility

27. Initial Drug Regimen:

	NO	YES	UNK.		NO	YES	UNK.		NO	YES	UNK.
Isoniazid	0 ☐	1 ☐	9 ☐	Ethionamide	0 ☐	1 ☐	9 ☐	Amikacin	0 ☐	1 ☐	9 ☐
Rifampin	0 ☐	1 ☐	9 ☐	Kanamycin	0 ☐	1 ☐	9 ☐	Rifabutine	0 ☐	1 ☐	9 ☐
Pyrazinamide	0 ☐	1 ☐	9 ☐	Cycloserine	0 ☐	1 ☐	9 ☐	Ciprofloxacin	0 ☐	1 ☐	9 ☐
Ethambutol	0 ☐	1 ☐	9 ☐	Capreomycin	0 ☐	1 ☐	9 ☐	Ofloxacin	0 ☐	1 ☐	9 ☐
Streptomycin	0 ☐	1 ☐	9 ☐	Para-Amino Salicylic Acid	0 ☐	1 ☐	9 ☐	Other	0 ☐	1 ☐	9 ☐

28. Date Therapy Started:
Mo. ☐☐ Day ☐☐ Yr. ☐☐

29. Injecting Drug Use Within Past Year:
0 ☐ No 1 ☐ Yes 9 ☐ Unknown

30. Non-Injecting Drug Use Within Past Year:
0 ☐ No 1 ☐ Yes 9 ☐ Unknown

31. Excess Alcohol Use Within Past Year:
0 ☐ No 1 ☐ Yes 9 ☐ Unknown

32. Occupation *(Check all that apply within the past 24 months):*
1 ☐ Health Care Worker 3 ☐ Migratory Agricultural Worker 5 ☐ Not Employed within Past 24 Months
2 ☐ Correctional Employee 4 ☐ Other Occupation 9 ☐ Unknown

Comments:

1st Copy

2nd Copy

3rd Copy