

A. Demographic			EDN TB Follow-Up Worksheet		Last reviewed: 6/21/2013		
A1. Name (Last, First, Middle):		A2. Alien #:		A3. Visa type:		A4. Initial U.S. entry date:	
A5. Age:	A6. Gender:	A7. DOB: _____/_____/_____		A8. TB Class:			
A9. Country of examination:				A10. Country of birth:			
A11a. Address:				A12. a. Sponsor agency name:			
A11b. Phone:				b. Phone(s):			
A11c. Other:				c. Address:			
B. Jurisdictional Information							
B1. Arrival jurisdiction:			B2. Current jurisdiction:				
C. U.S. Evaluation							
C1. Date of Initial U.S. medical evaluation: _____/_____/_____							
Mantoux Tuberculin Skin Test (TST)				Interferon-Gamma Release Assay (IGRA)			
C2a. Was a TST administered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				C3a. Was IGRA administered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If YES, C2b. TST placement date: _____/_____/_____				If YES, C3b. Date collected: _____/_____/_____ <input type="checkbox"/> Date unknown			
<input type="checkbox"/> Placement date unknown				C3c. IGRA brand: <input type="checkbox"/> QuantiFERON® <input type="checkbox"/> T-SPOT			
C2c. TST mm: _____ <input type="checkbox"/> Unknown				<input type="checkbox"/> Other (specify):			
C2d. TST interpretation: <input type="checkbox"/> Positive <input type="checkbox"/> Negative				C3d. Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate			
<input type="checkbox"/> Unknown				<input type="checkbox"/> Invalid <input type="checkbox"/> Unknown			
C2e. History of Previous Positive TST <input type="checkbox"/>				C3e. History of previous positive IGRA <input type="checkbox"/>			
U.S. Review of Pre-Immigration CXR			U.S. Domestic CXR		Comparison		
C4. Pre-immigration CXR available?			C7. U.S. domestic CXR done?		C11. U.S. domestic CXR comparison to pre-immigration CXR:		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Verifiable			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Stable		
C5. U.S. interpretation of pre-immigration CXR:			If YES, C8. Date of U.S. CXR: _____/_____/_____		<input type="checkbox"/> Worsening		
<input type="checkbox"/> Normal			C9. Interpretation of U.S. CXR:		<input type="checkbox"/> Improving		
<input type="checkbox"/> Abnormal (must select one below):			<input type="checkbox"/> Normal		<input type="checkbox"/> Unknown		
<input type="checkbox"/> Not consistent with active TB			<input type="checkbox"/> Abnormal (must select one below):				
<input type="checkbox"/> Non-cavitary, consistent with TB			<input type="checkbox"/> Not consistent with active TB				
<input type="checkbox"/> Cavitary, consistent with TB			<input type="checkbox"/> Non-cavitary, consistent with TB				
<input type="checkbox"/> Poor Quality			<input type="checkbox"/> Cavitary, consistent with TB				
<input type="checkbox"/> Unknown			<input type="checkbox"/> Unknown				
C6. Other pre-immigration CXR abnormalities:			C10. U.S. domestic CXR abnormalities:				
<input type="checkbox"/> Volume loss <input type="checkbox"/> Infiltrate <input type="checkbox"/> Granuloma(ta)			<input type="checkbox"/> Volume loss <input type="checkbox"/> Infiltrate <input type="checkbox"/> Granuloma(ta)				
<input type="checkbox"/> Adenopathy <input type="checkbox"/> Other (specify)			<input type="checkbox"/> Adenopathy <input type="checkbox"/> Other (specify)				
U.S. Review of Pre-Immigration Treatment							
C12a. Completed treatment pre-immigration? <input type="checkbox"/> Yes <input type="checkbox"/> No				C13. Arrived on treatment?			
If YES, <input type="checkbox"/> Treated for TB disease <input type="checkbox"/> Treated for LTBI				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
C12b. Treatment start date: _____/_____/_____ <input type="checkbox"/> Start date unknown				If YES, <input type="checkbox"/> TB disease <input type="checkbox"/> LTBI			
C12c. Treatment end date: _____/_____/_____ <input type="checkbox"/> End date unknown				C13a. Start date: _____/_____/_____ <input type="checkbox"/> Start date unknown			
C12d. Treatment reported by:				C14. Pre-Immigration treatment concerns?			
<input type="checkbox"/> Treatment documented on DS forms				<input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Patient reported treatment completion <b>at</b> or <b>before</b> panel physician examination				If YES,			
<input type="checkbox"/> Both-documented on DS forms & patient reported				<input type="checkbox"/> Treatment duration too short			
<input type="checkbox"/> Unknown				<input type="checkbox"/> Incorrect treatment regimen			
C12e. Standard TB treatment regimen was administered?				<input type="checkbox"/> Other, please specify:			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to verify							

**C15. U.S. Microscopy/Bacteriology\*** Sputa collected in U.S.?  Yes  No \*Covers all results regardless of sputa collection method.

#	Date Collected	AFB Smear	Sputum Culture	Drug Susceptibility Testing
1	_/_/____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown	<input type="checkbox"/> NTM <input type="checkbox"/> MTB Complex <input type="checkbox"/> Contaminated <input type="checkbox"/> Negative <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown	<input type="checkbox"/> MDR-TB <input type="checkbox"/> Mono-RIF <input type="checkbox"/> Mono-INH <input type="checkbox"/> Other DR <input type="checkbox"/> No DR <input type="checkbox"/> Not Done
2	_/_/____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown	<input type="checkbox"/> NTM <input type="checkbox"/> MTB Complex <input type="checkbox"/> Contaminated <input type="checkbox"/> Negative <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown	<input type="checkbox"/> MDR-TB <input type="checkbox"/> Mono-RIF <input type="checkbox"/> Mono-INH <input type="checkbox"/> Other DR <input type="checkbox"/> No DR <input type="checkbox"/> Not Done
3	_/_/____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown	<input type="checkbox"/> NTM <input type="checkbox"/> MTB Complex <input type="checkbox"/> Contaminated <input type="checkbox"/> Negative <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown	<input type="checkbox"/> MDR-TB <input type="checkbox"/> Mono-RIF <input type="checkbox"/> Mono-INH <input type="checkbox"/> Other DR <input type="checkbox"/> No DR <input type="checkbox"/> Not Done

**D. Evaluation Disposition**

D1. Evaluation disposition date: \_/\_/\_\_\_\_

D2. Evaluation disposition:

Completed evaluation     Initiated Evaluation / Not completed     Did not initiate evaluation  
If evaluation was completed, was treatment recommended?    If evaluation was NOT completed, why not?

Yes     No     Not Located     Moved within U.S., transferred to:  
 LTBI     Lost to Follow-Up     Moved outside U.S.  
 Active TB     Refused Evaluation     Died  
 Unknown     Other, specify

D3. Diagnosis

Class 0 - No TB exposure, not infected     Class 1 - TB exposure, no evidence of infection  
 Class 2 - TB infection, no disease     Class 3 - TB, TB disease  
 Class 4 - TB, inactive disease     Pulmonary     Extra-pulmonary     Both sites

D If diagnosed with TB disease,  RVCT Reported    D5. RVCT #: \_\_\_\_\_     RVCT # unknown

**E. U.S. Treatment**

E1. U.S. treatment initiated:  Yes     No     Unknown

*If NO, specify the reason:*

Patient declined against medical advice     Lost to follow-up     Moved within U.S., transferred to:  
 Died     Moved outside the U.S.     Other (specify)  
 Unknown

*If YES:*  TB disease     LTBI

E2. Treatment start date: \_/\_/\_\_\_\_

E3. U.S. treatment completed:  Yes     No     Unknown

*If NO, specify the reason:*

Patient stopped against medical advice     Lost to follow-up     Adverse effect  
 Provider decision     Moved outside the U.S.     Moved within U.S., transferred to:  
 Died     Unknown     Other (specify)

*If treatment was completed,*    E4. Treatment completion date: \_/\_/\_\_\_\_

*If treatment was initiated but NOT completed,*    E5. Treatment end date: \_/\_/\_\_\_\_

**F. Comments**

**G. Screen Site Information**

Provider's Name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_