2020 RVCT MDSS TRAINING

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GENERAL GUIDELINES

- Leave the item blank if the information requested is pending.
- If the valid value cannot be determined and there is no check-box labeled “unknown” first make sure you need to be answering the question, then write “unknown.”
- Unknown information should be rare.
- Dates must be entered fully as mm/dd/yyyy. If a day is truly unknown (ex: day entered U.S.) enter it as 01.
- Text box fields other than name, date of birth, and address should not contain personal identifiers

ADMINISTRATIVE INFORMATION

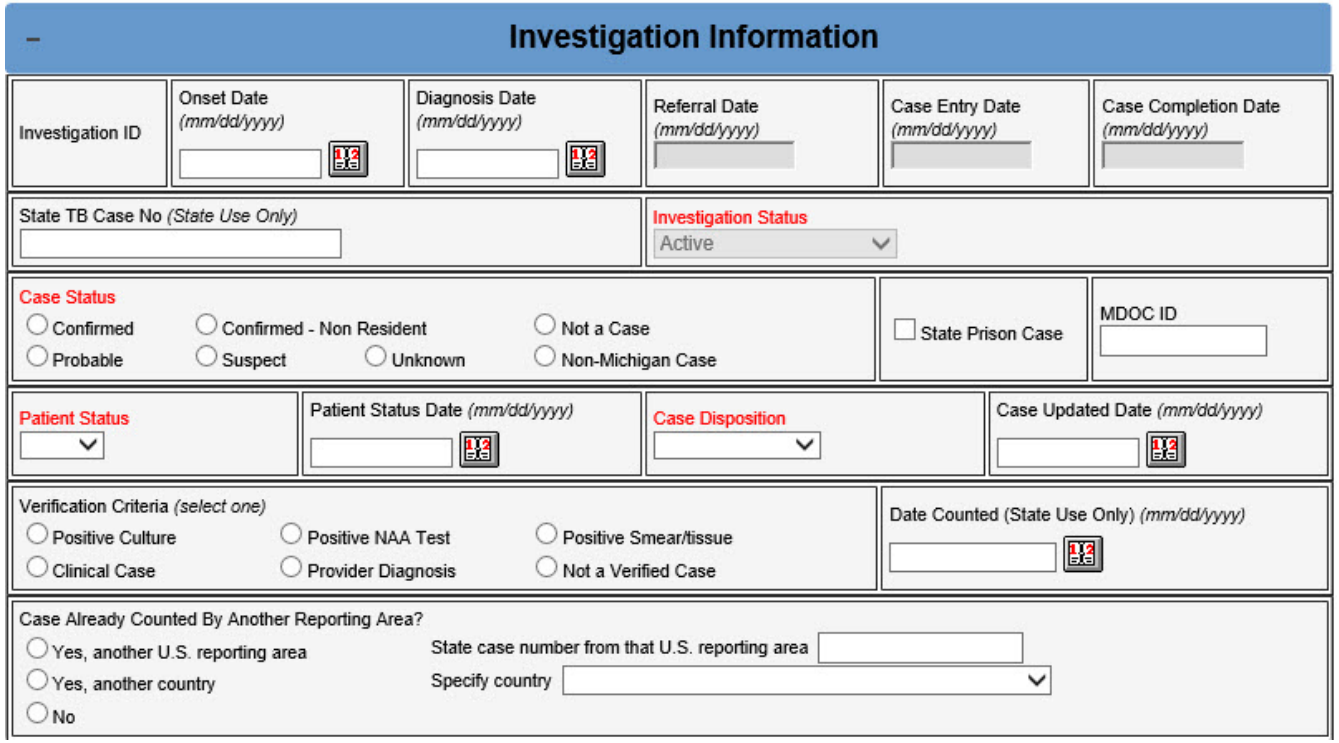
Date of Illness Onset/Symptom Start Date

Date Reported (Referral Date)

Date Counted

State Case Number

Case Already Counted by Another Reporting Area?



ADMINISTRATIVE INFORMATION

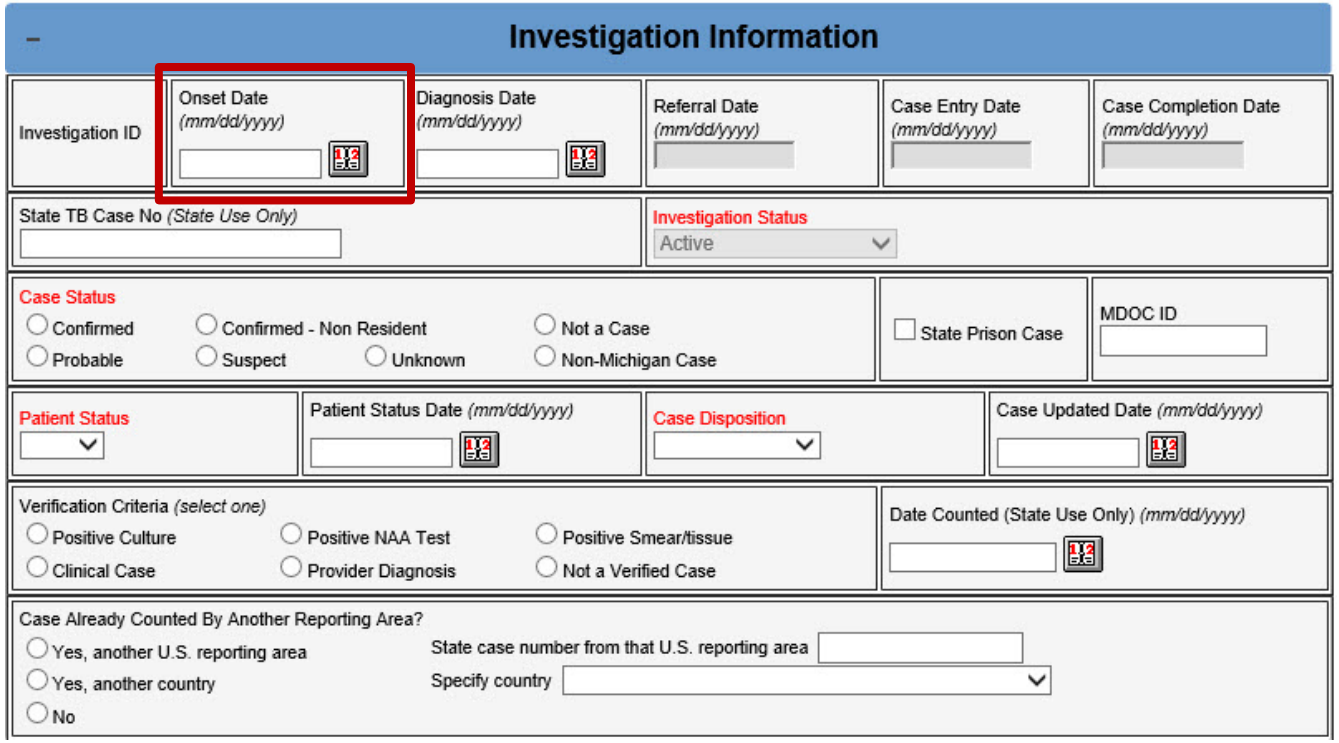
Date of Illness Onset/Symptom Start Date

Date Reported (Referral Date)

Date Counted

State Case Number

Case Already Counted by Another Reporting Area?



Date illness/symptoms started for this TB episode

Purpose: To establish the approximate symptom start date to facilitate calculation of infectious period and time from illness onset to diagnosis.

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ADMINISTRATIVE INFORMATION

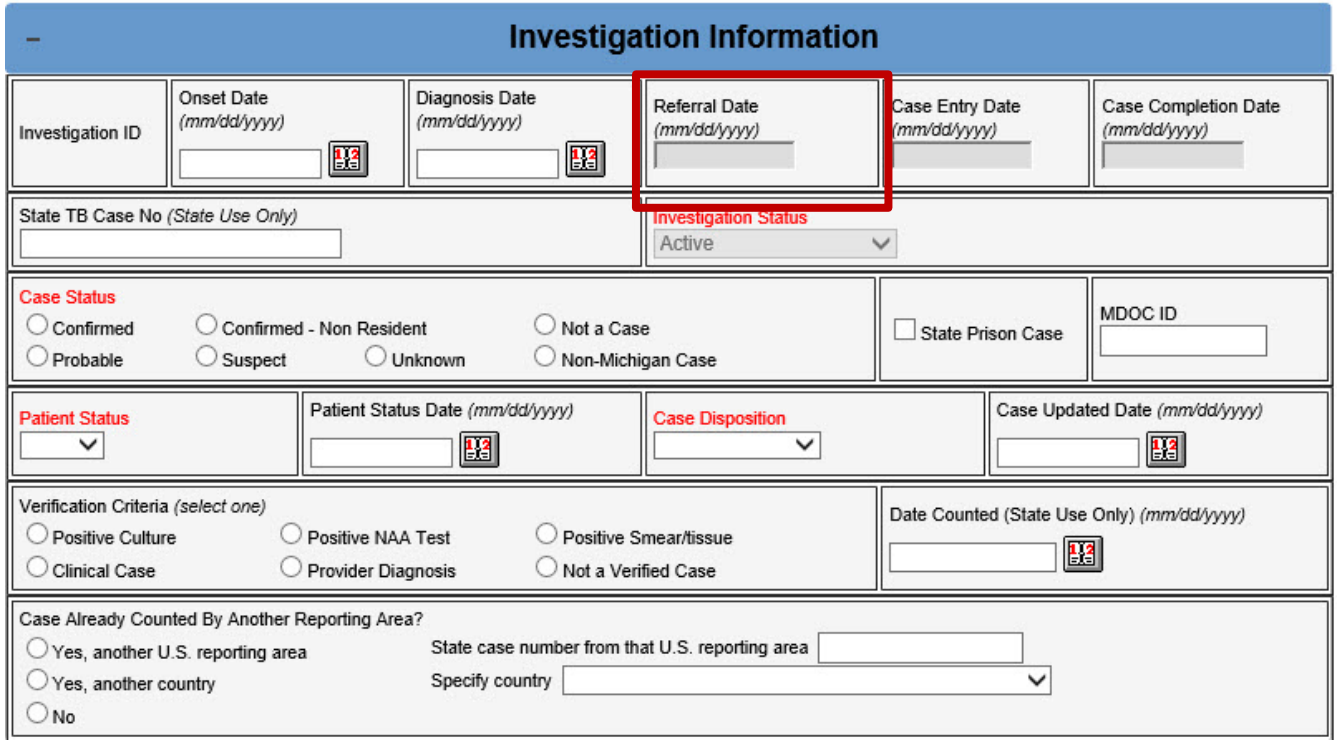
Date of Illness Onset/Symptom Start Date

Date Reported (Referral Date)

Date Counted

State Case Number

Case Already Counted by Another Reporting Area?



Date that a health department first **thought** that the patient may have TB *or*
Date the health department received notification (verbal or written) from a health care provider that a person might have TB

Purpose: The Date Reported is used to determine when the health department was first notified that a person may have TB.

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ADMINISTRATIVE INFORMATION

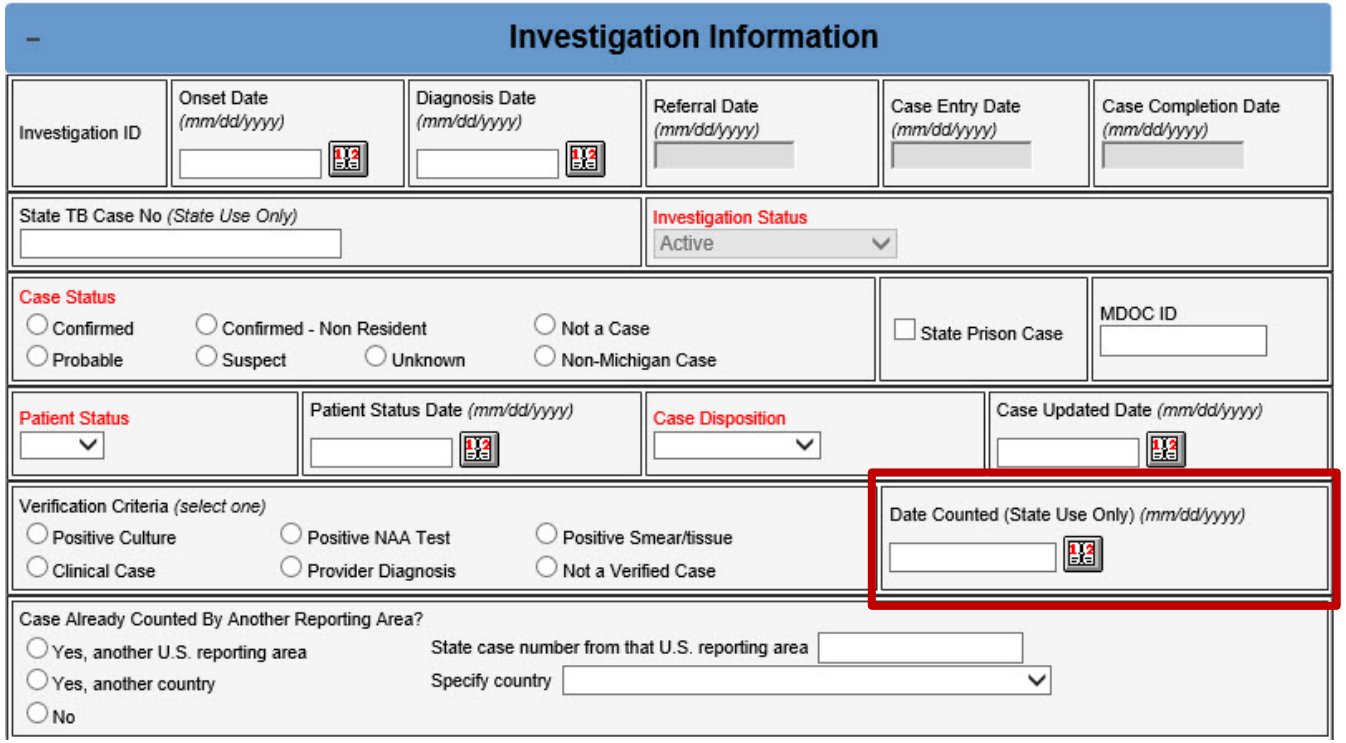
Date of Illness Onset/Symptom Start Date

Date Reported (Referral Date)

Date Counted

State Case Number

Case Already Counted by Another Reporting Area?



Date when the state health department verified that the case meets the case definition for TB disease.

This will always be entered by the MDHHS TB Unit

Purpose: Used to determine the approximate date that the reporting area reviewed the RVCT and determined that the case meets the official TB surveillance case definition.

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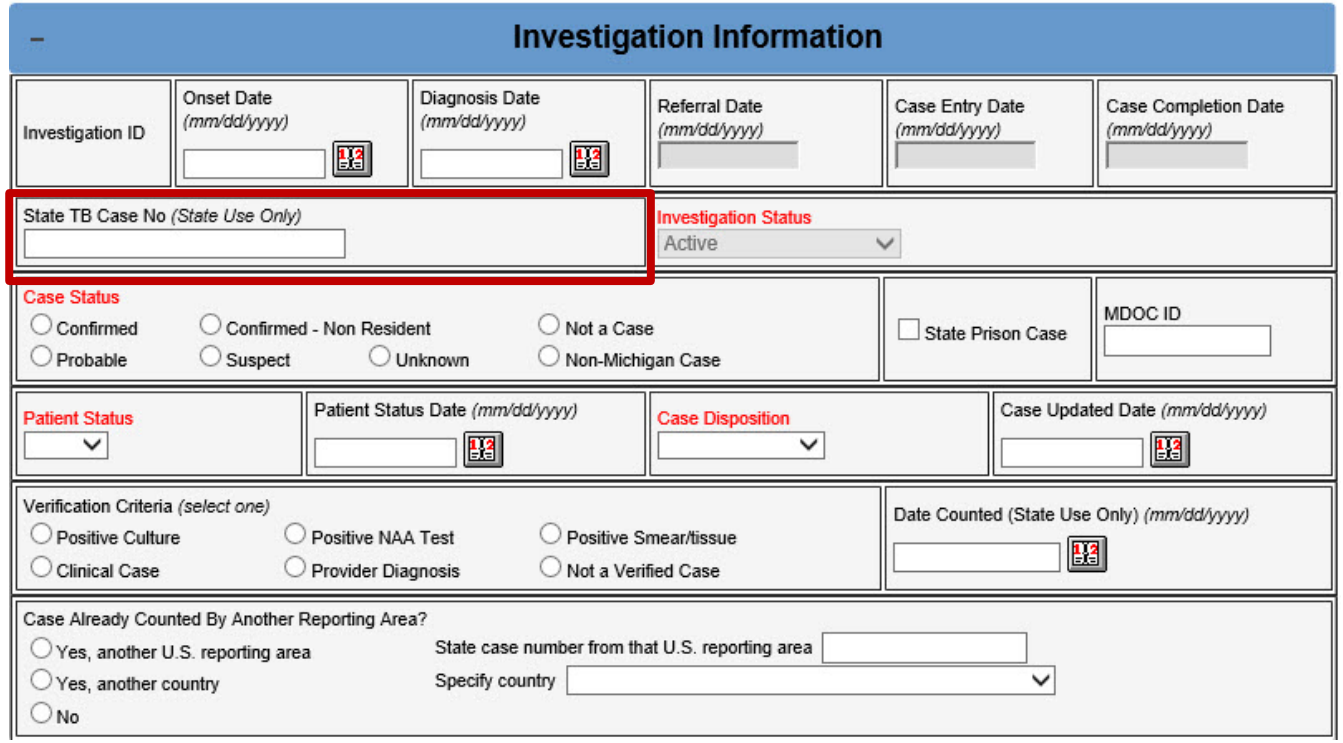
ADMINISTRATIVE INFORMATION



Date of Illness Onset/Symptom Start Date

Date Reported (Referral Date)

Date Counted

State Case Number

Case Already Counted by Another Reporting Area?

Year + State + Number = State Case Number

Year Reported is the year when the case was reported (e.g. 2020)

State Code indicates the two-letter postal code of the state reporting this case (e.g. MI)

Nine-character string unique within the reporting area

This will always be entered by the MDHHS TB Unit

Purpose: Used to uniquely identify case reports to facilitate communication between reporting areas and CDC

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ADMINISTRATIVE INFORMATION

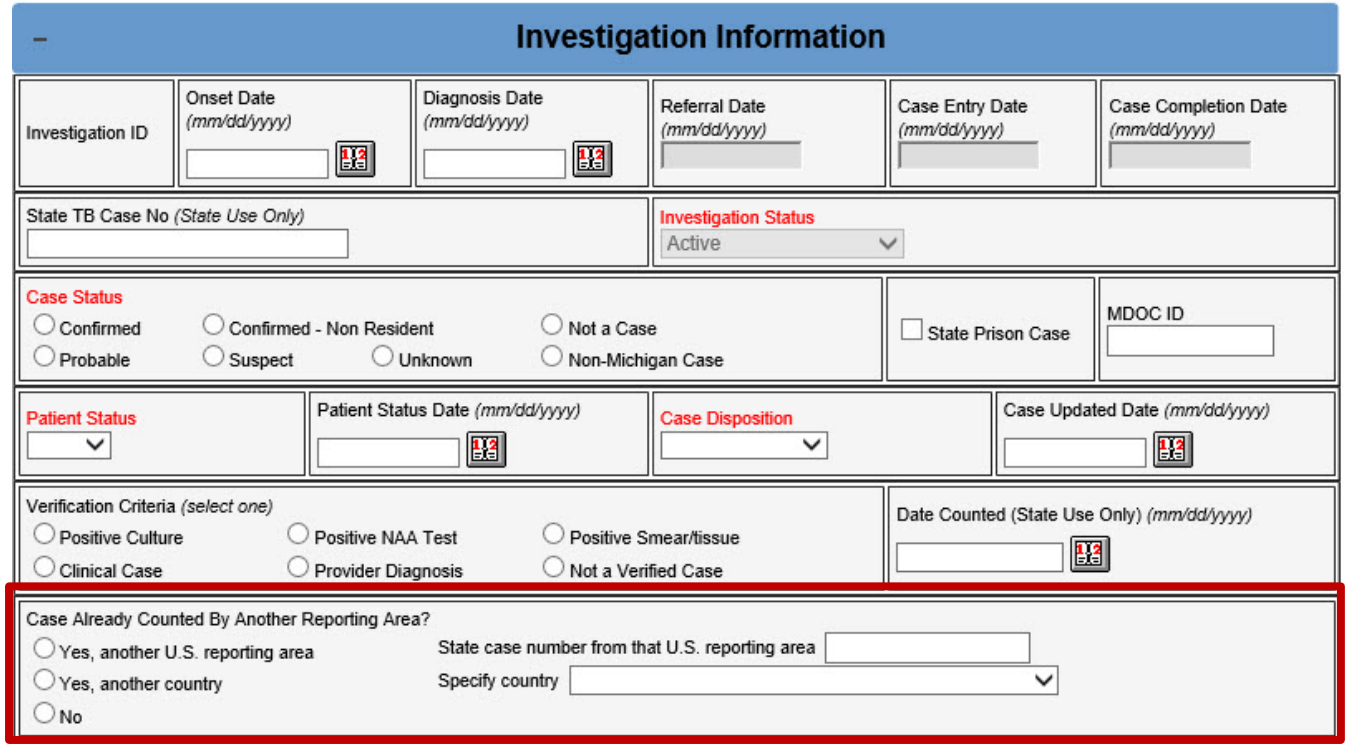
Date of Illness Onset/Symptom Start Date

Date Reported (Referral Date)

Date Counted

State Case Number

Case Already Counted by Another Reporting Area?



Specify whether the case has been counted by another U.S. reporting area or another county. If so, specify the U.S. reporting area state case number or country. **This will usually be entered by the MDHHS TB Unit**

Purpose: TB cases may be reported by multiple reporting areas in the event that the patient moved between reporting areas while under care for a TB episode; however, to avoid double-counting the case, it is important that only one reporting area officially "count" the case. This question helps to determine whether the case report should be considered "countable" for incidence calculations.

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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)*
15094199579			06/25/2020	06/25/2020	

State TB Case No *(State Use Only)*: 2020MI000000099

Investigation Status: Review

Case Status

- (●) Confirmed
- ( ) Confirmed - Non Resident
- ( ) Not a Case
- ( ) Probable
- ( ) Suspect
- ( ) Unknown
- ( ) Non-Michigan Case

[ ] State Prison Case

MDOC ID:

Patient Status	Patient Status Date *(mm/dd/yyyy)*	Case Disposition	Case Updated Date *(mm/dd/yyyy)*
Alive	06/25/2020	OUTPATIENT	06/25/2020

Verification Criteria *(select one)*

- (●) Positive Culture
- ( ) Positive NAA Test
- ( ) Positive Smear/tissue
- ( ) Clinical Case
- ( ) Provider Diagnosis
- ( ) Not a Verified Case

Date Counted (State Use Only) *(mm/dd/yyyy)*: 06/25/2020

Case Already Counted By Another Reporting Area?

- ( ) Yes, another U.S. reporting area
- ( ) Yes, another country
- (●) No

State case number from that U.S. reporting area:

Specify country:

DEMOGRAPHICS & INITIAL EVALUATION

Reporting Address

Date of Birth

Sex at Birth

Ethnicity

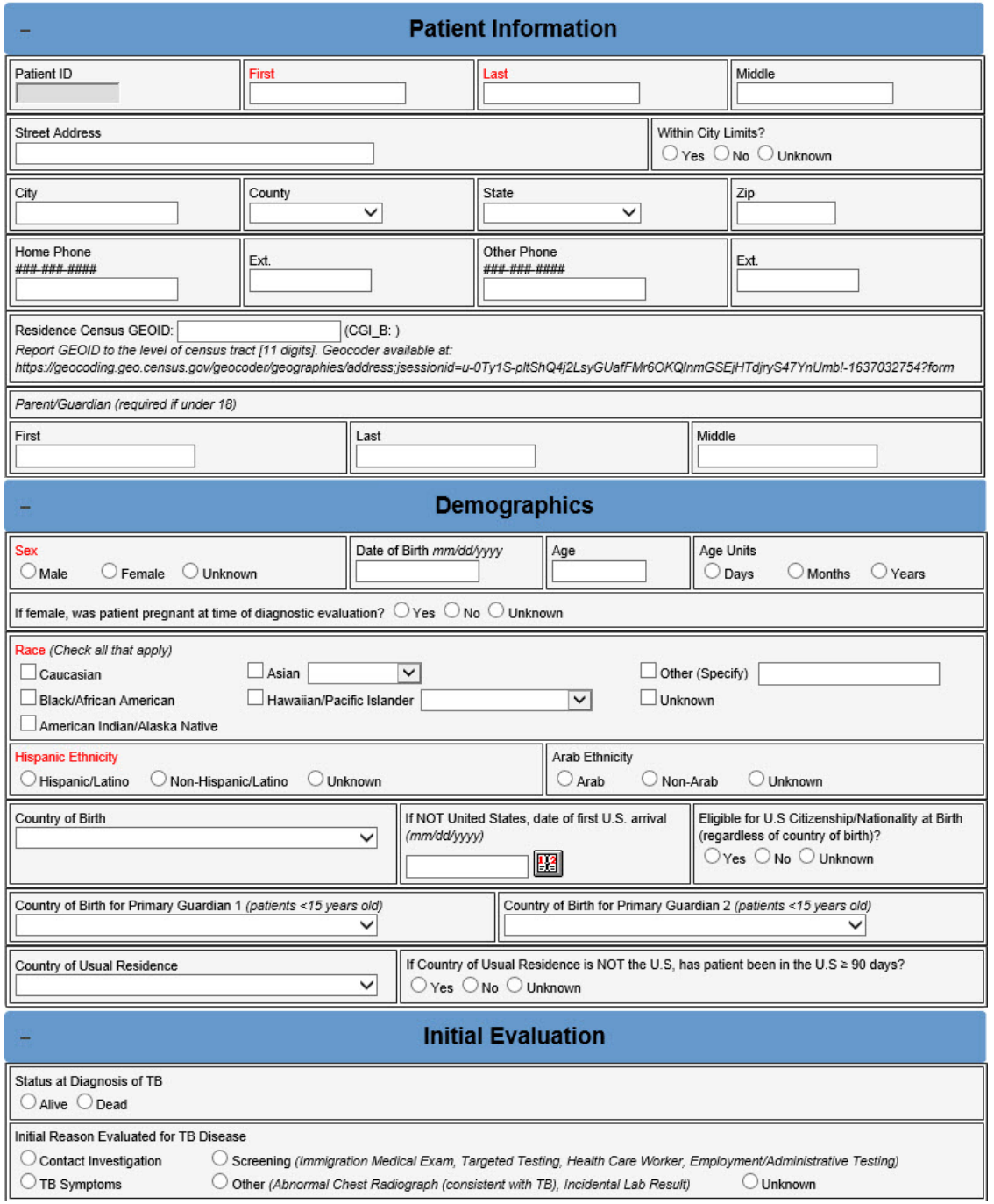
Race

Nativity

Country of Usual Residence

Status at TB Diagnosis

Initial Reason Evaluated for TB



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.

Residence Census GEOID: (CGI_B:)

Report GEOID to the level of census tract [11 digits]. Geocoder available at:
https://geocoding.geo.census.gov/geocoder/geographies/address;jsessionid=u-0Ty1S-pltShQ4j2LsyGUafFMr6OKQlnmGSEjHTdjryS47YnUmb!-1637032754?form

Parent/Guardian (required if under 18)

First | Last | Middle

Demographics

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

If female, was patient pregnant at time of diagnostic evaluation? ○ Yes ○ No ○ Unknown

Race *(Check all that apply)*

☐ Caucasian ☐ Asian ☐ Other (Specify)

☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Unknown

☐ American Indian/Alaska Native

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

Country of Birth | If NOT United States, date of first U.S. arrival *(mm/dd/yyyy)* | Eligible for U.S Citizenship/Nationality at Birth (regardless of country of birth)? ○ Yes ○ No ○ Unknown

Country of Birth for Primary Guardian 1 *(patients <15 years old)* | Country of Birth for Primary Guardian 2 *(patients <15 years old)*

Country of Usual Residence | If Country of Usual Residence is NOT the U.S, has patient been in the U.S ≥ 90 days? ○ Yes ○ No ○ Unknown

Initial Evaluation

Status at Diagnosis of TB ○ Alive ○ Dead

Initial Reason Evaluated for TB Disease

○ Contact Investigation ○ Screening *(Immigration Medical Exam, Targeted Testing, Health Care Worker, Employment/Administrative Testing)*

○ TB Symptoms ○ Other *(Abnormal Chest Radiograph (consistent with TB), Incidental Lab Result)* ○ Unknown

DEMOGRAPHICS & INITIAL EVALUATION

Reporting Address

Date of Birth

Sex at Birth

Ethnicity

Race

Nativity

Country of Usual Residence

Status at TB Diagnosis

Initial Reason Evaluated for TB

Purpose: To document the approximate location of the patient's residence for the purpose of geographic analyses and correct assignment of the case to a public health jurisdiction.

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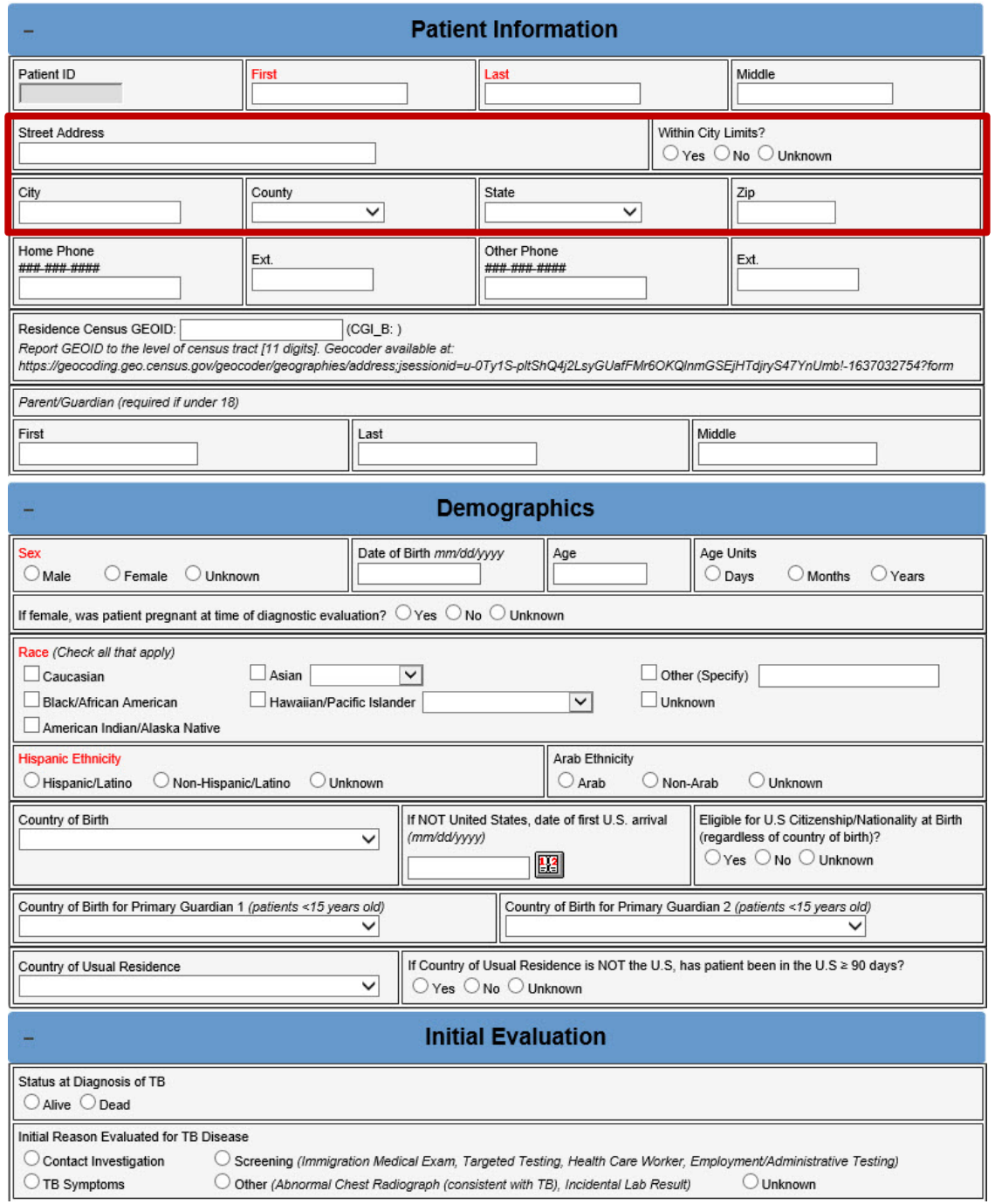

Patient Information

Patient ID | First | Last | Middle

Street Address | Within City Limits? Yes No Unknown

City | County | State | Zip

Home Phone ### ### #### | Ext. | Other Phone ### ### #### | Ext.

Residence Census GEOID: (CGI_B:)
Report GEOID to the level of census tract [11 digits]. Geocoder available at:
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Parent/Guardian (required if under 18)

First | Last | Middle

Demographics

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

If female, was patient pregnant at time of diagnostic evaluation? Yes No Unknown

Race *(Check all that apply)*
Caucasian; Asian; Other (Specify); Black/African American; Hawaiian/Pacific Islander; Unknown; American Indian/Alaska Native

Hispanic Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unknown | Arab Ethnicity: Arab Non-Arab Unknown

Country of Birth | If NOT United States, date of first U.S. arrival *(mm/dd/yyyy)* | Eligible for U.S Citizenship/Nationality at Birth (regardless of country of birth)? Yes No Unknown

Country of Birth for Primary Guardian 1 *(patients <15 years old)* | Country of Birth for Primary Guardian 2 *(patients <15 years old)*

Country of Usual Residence | If Country of Usual Residence is NOT the U.S, has patient been in the U.S ≥ 90 days? Yes No Unknown

Initial Evaluation

Status at Diagnosis of TB: Alive Dead

Initial Reason Evaluated for TB Disease
Contact Investigation; Screening *(Immigration Medical Exam, Targeted Testing, Health Care Worker, Employment/Administrative Testing)*; TB Symptoms; Other *(Abnormal Chest Radiograph (consistent with TB), Incidental Lab Result)*; Unknown

DEMOGRAPHICS & INITIAL EVALUATION

Reporting Address

Date of Birth

Sex at Birth

Ethnicity

Race

Nativity

Country of Usual Residence

Status at TB Diagnosis

Initial Reason Evaluated for TB

Purpose: To document the approximate location of the patient's residence for the purpose of geographic analyses and correct assignment of the case to a public health jurisdiction.

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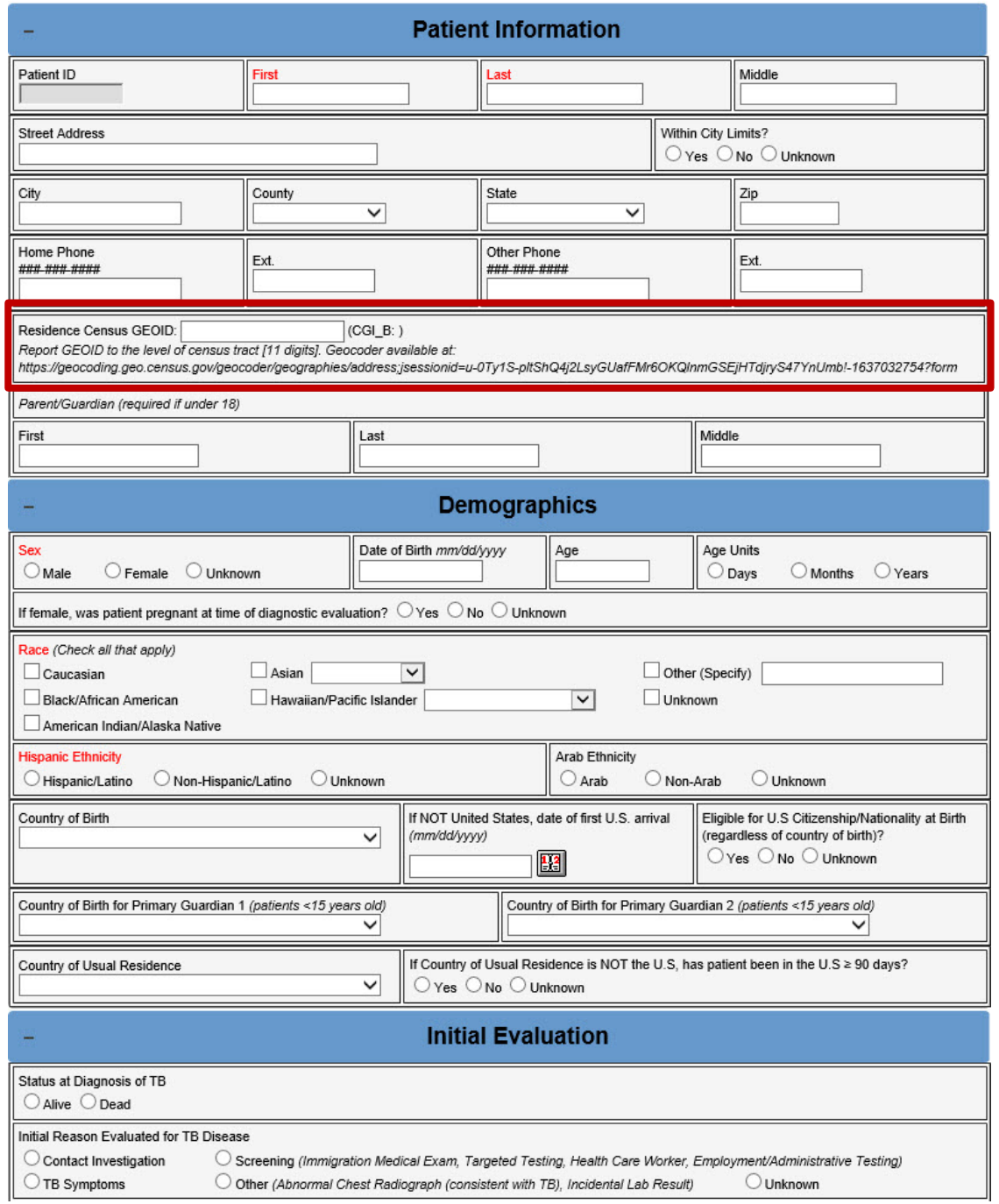


Patient Information

Patient ID | First | Last | Middle

Street Address | Within City Limits? Yes No Unknown

City | County | State | Zip

Home Phone ### ### #### | Ext. | Other Phone ### ### #### | Ext.

Residence Census GEOID: (CGI_B:)
Report GEOID to the level of census tract [11 digits]. Geocoder available at:
https://geocoding.geo.census.gov/geocoder/geographies/address;jsessionid=u-0Ty1S-pltShQ4j2LsyGUafFMr6OKQlnmGSEjHTdjryS47YnUmb!-1637032754?form

Parent/Guardian (required if under 18)

First | Last | Middle

Demographics

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

If female, was patient pregnant at time of diagnostic evaluation? Yes No Unknown

Race *(Check all that apply)*
Caucasian | Asian | Other (Specify)
Black/African American | Hawaiian/Pacific Islander | Unknown
American Indian/Alaska Native

Hispanic Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unknown | Arab Ethnicity: Arab Non-Arab Unknown

Country of Birth | If NOT United States, date of first U.S. arrival *(mm/dd/yyyy)* | Eligible for U.S Citizenship/Nationality at Birth (regardless of country of birth)? Yes No Unknown

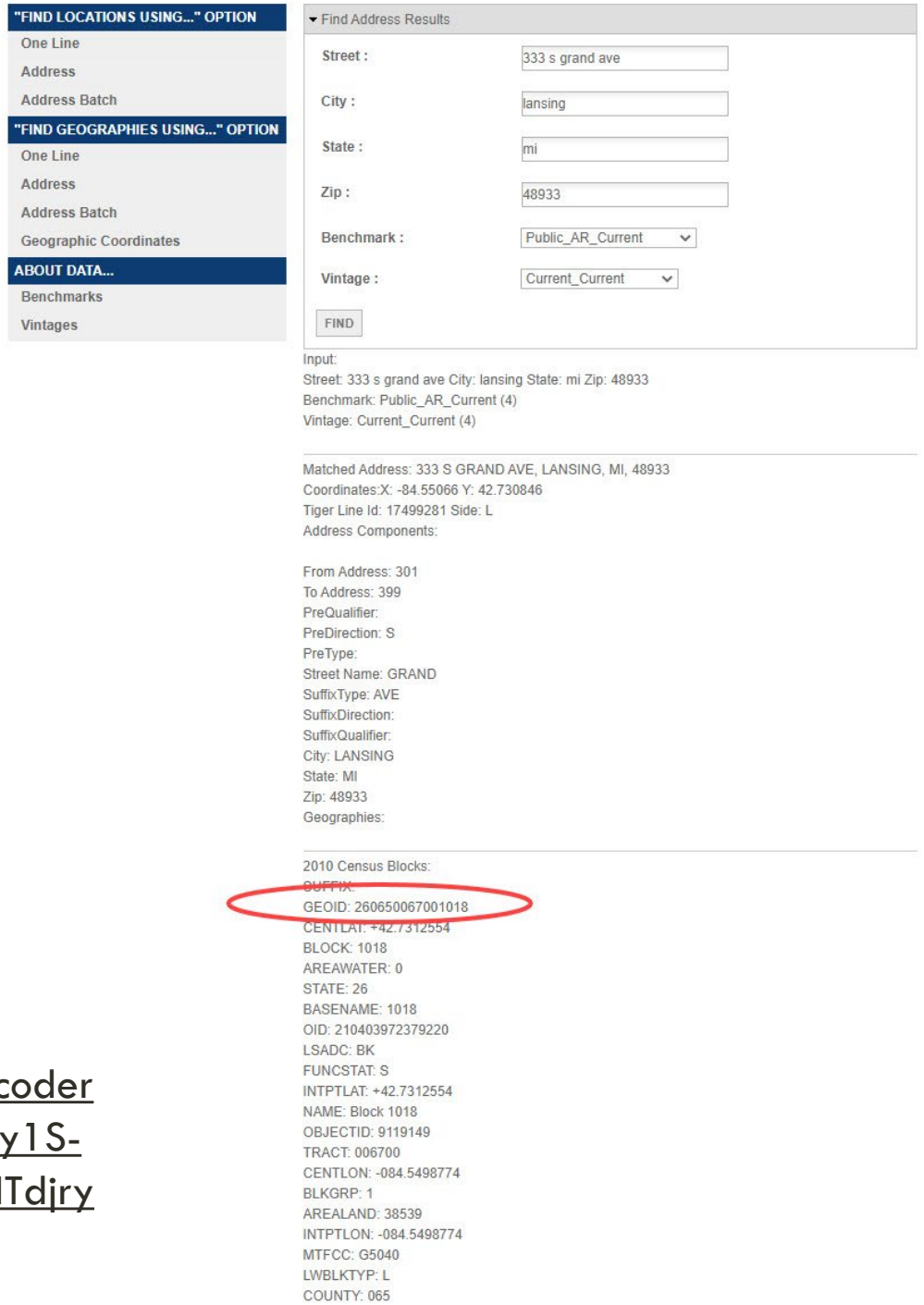
Country of Birth for Primary Guardian 1 *(patients <15 years old)* | Country of Birth for Primary Guardian 2 *(patients <15 years old)*

Country of Usual Residence | If Country of Usual Residence is NOT the U.S, has patient been in the U.S ≥ 90 days? Yes No Unknown

Initial Evaluation

Status at Diagnosis of TB: Alive Dead

Initial Reason Evaluated for TB Disease
Contact Investigation | Screening *(Immigration Medical Exam, Targeted Testing, Health Care Worker, Employment/Administrative Testing)*
TB Symptoms | Other *(Abnormal Chest Radiograph (consistent with TB), Incidental Lab Result)* | Unknown



https://geocoding.geo.census.gov/geocoder/geographies/address;jsessionid=u-0Ty1S-pltShQ4j2LsyGUafFMr6OKQlnmGSEjHTdjryS47YnUmb!-1637032754?form

DEMOGRAPHICS & INITIAL EVALUATION

Reporting Address

Date of Birth

Sex at Birth

Ethnicity

Race

Nativity

Country of Usual Residence

Status at TB Diagnosis

Initial Reason Evaluated for TB

Purpose: To document the approximate location of the patient's residence for the purpose of geographic analyses and correct assignment of the case to a public health jurisdiction.

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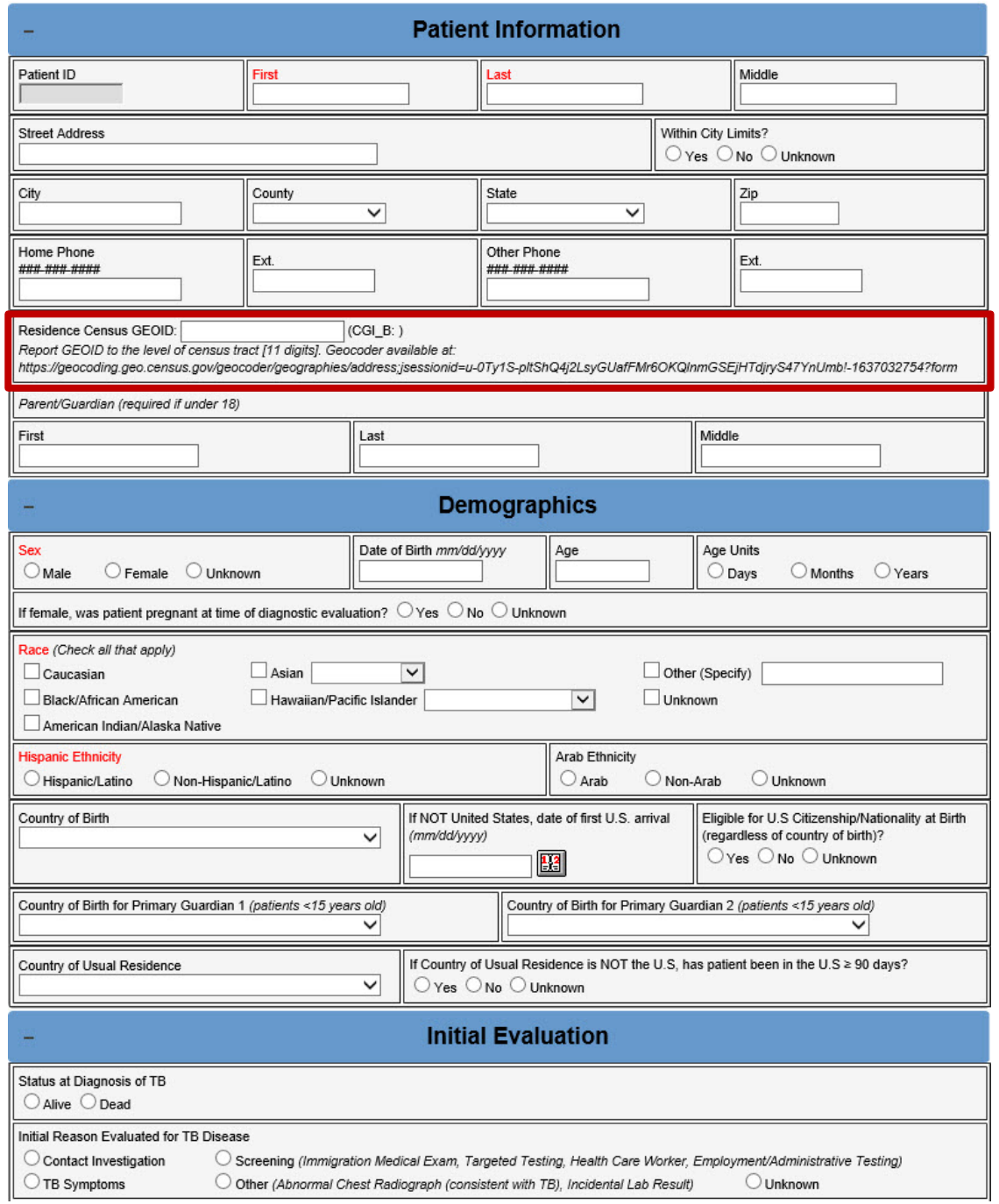

Patient Information

Patient ID | First | Last | Middle

Street Address | Within City Limits? Yes No Unknown

City | County | State | Zip

Home Phone ### ### #### | Ext. | Other Phone ### ### #### | Ext.

Residence Census GEOID: (CGI_B:)
Report GEOID to the level of census tract [11 digits]. Geocoder available at:
https://geocoding.geo.census.gov/geocoder/geographies/address;jsessionid=u-0Ty1S-pltShQ4j2LsyGUafFMr6OKQlnmGSEjHTdjryS47YnUmb!-1637032754?form

Parent/Guardian (required if under 18)

First | Last | Middle

Demographics

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

If female, was patient pregnant at time of diagnostic evaluation? Yes No Unknown

Race *(Check all that apply)*
Caucasian | Asian | Other (Specify)
Black/African American | Hawaiian/Pacific Islander | Unknown
American Indian/Alaska Native

Hispanic Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unknown | Arab Ethnicity: Arab Non-Arab Unknown

Country of Birth | If NOT United States, date of first U.S. arrival *(mm/dd/yyyy)* | Eligible for U.S Citizenship/Nationality at Birth (regardless of country of birth)? Yes No Unknown

Country of Birth for Primary Guardian 1 *(patients <15 years old)* | Country of Birth for Primary Guardian 2 *(patients <15 years old)*

Country of Usual Residence | If Country of Usual Residence is NOT the U.S, has patient been in the U.S ≥ 90 days? Yes No Unknown

Initial Evaluation

Status at Diagnosis of TB: Alive Dead

Initial Reason Evaluated for TB Disease
Contact Investigation | Screening *(Immigration Medical Exam, Targeted Testing, Health Care Worker, Employment/Administrative Testing)*
TB Symptoms | Other *(Abnormal Chest Radiograph (consistent with TB), Incidental Lab Result)* | Unknown

DEMOGRAPHICS & INITIAL EVALUATION

Reporting Address

Date of Birth

Sex at Birth

Ethnicity

Race

Nativity

Country of Usual Residence

Status at TB Diagnosis

Initial Reason Evaluated for TB

Patient's complete date of birth should be entered.

Purpose: To calculate the patient's age at the time of relevant events in the patient's lifetime

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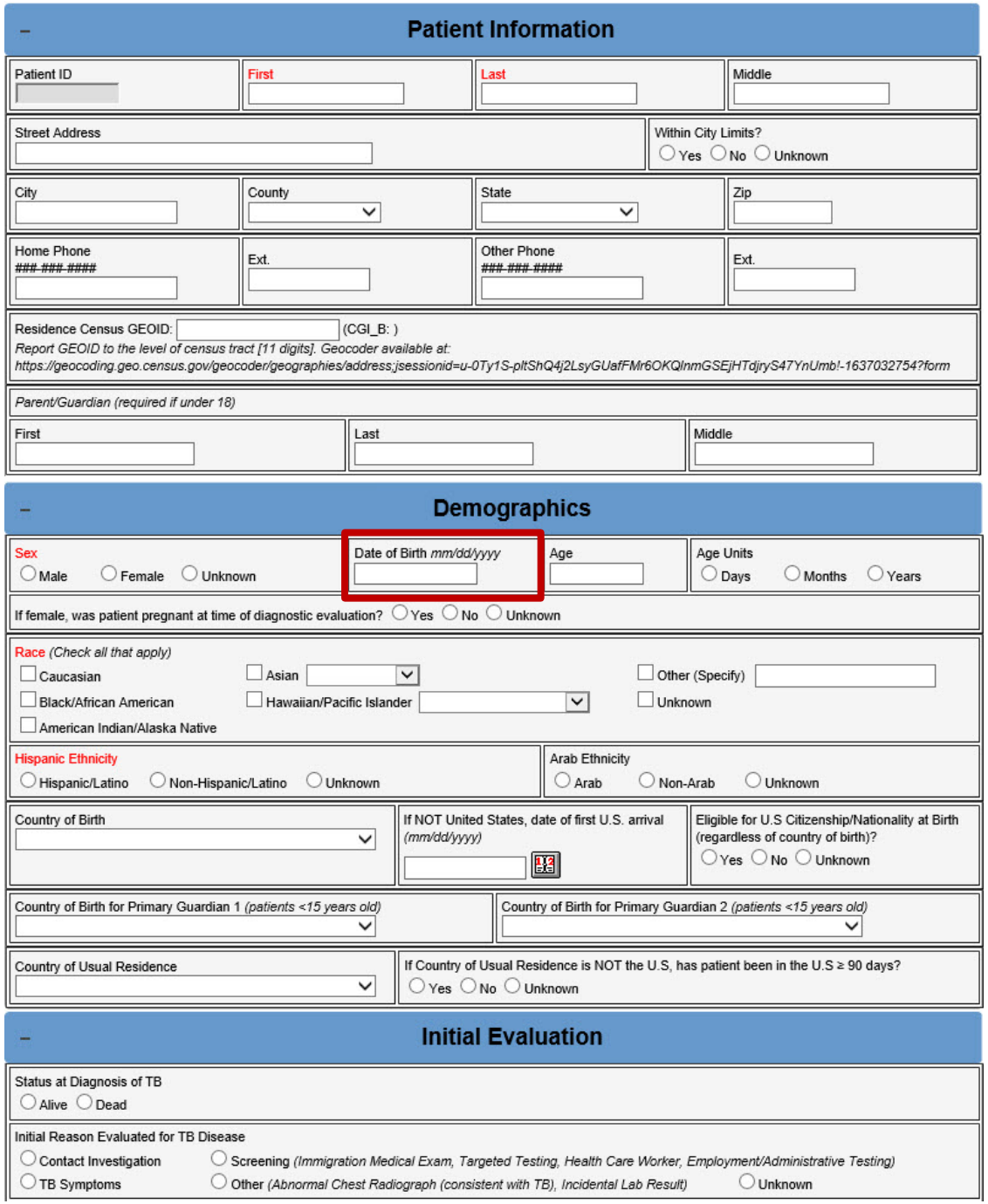

Patient Information

Patient ID | First | Last | Middle

Street Address | Within City Limits? Yes No Unknown

City | County | State | Zip

Home Phone ### ### #### | Ext. | Other Phone ### ### #### | Ext.

Residence Census GEOID: (CGI_B:)
Report GEOID to the level of census tract [11 digits]. Geocoder available at:
https://geocoding.geo.census.gov/geocoder/geographies/address;jsessionid=u-0Ty1S-pltShQ4j2LsyGUafFMr6OKQlnmGSEjHTdjryS47YnUmb!-1637032754?form

Parent/Guardian (required if under 18)

First | Last | Middle

Demographics

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

If female, was patient pregnant at time of diagnostic evaluation? Yes No Unknown

Race *(Check all that apply)*
Caucasian | Asian | Other (Specify)
Black/African American | Hawaiian/Pacific Islander | Unknown
American Indian/Alaska Native

Hispanic Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unknown | Arab Ethnicity: Arab Non-Arab Unknown

Country of Birth | If NOT United States, date of first U.S. arrival *(mm/dd/yyyy)* | Eligible for U.S Citizenship/Nationality at Birth (regardless of country of birth)? Yes No Unknown

Country of Birth for Primary Guardian 1 *(patients <15 years old)* | Country of Birth for Primary Guardian 2 *(patients <15 years old)*

Country of Usual Residence | If Country of Usual Residence is NOT the U.S, has patient been in the U.S ≥ 90 days? Yes No Unknown

Initial Evaluation

Status at Diagnosis of TB: Alive Dead

Initial Reason Evaluated for TB Disease
Contact Investigation | Screening *(Immigration Medical Exam, Targeted Testing, Health Care Worker, Employment/Administrative Testing)*
TB Symptoms | Other *(Abnormal Chest Radiograph (consistent with TB), Incidental Lab Result)* | Unknown

DEMOGRAPHICS & INITIAL EVALUATION

Reporting Address

Date of Birth

Sex at Birth

Ethnicity

Race

Nativity

Country of Usual Residence

Status at TB Diagnosis

Initial Reason Evaluated for TB

Purpose: To establish the biological sex for the patient at birth for evaluation of epidemiologic trends

IF recorded female at birth, record if patient was pregnant when TB diagnostic evaluation was initiated.

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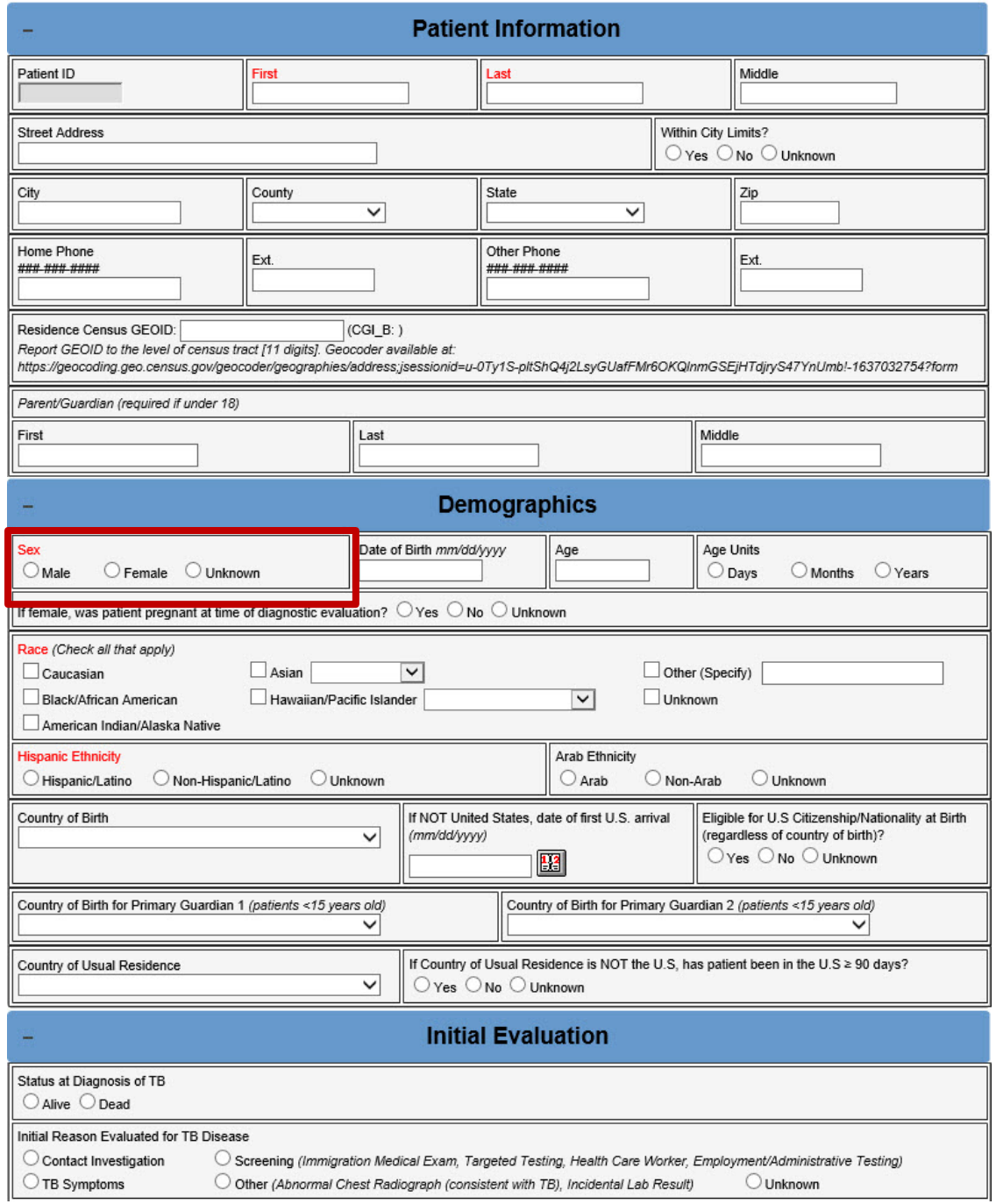

Patient Information

Patient ID | First | Last | Middle

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

City | County | State | Zip

Home Phone ### ### #### | Ext. | Other Phone ### ### #### | Ext.

Residence Census GEOID: (CGI_B:)
Report GEOID to the level of census tract [11 digits]. Geocoder available at:
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Parent/Guardian (required if under 18)

First | Last | Middle

Demographics

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

If female, was patient pregnant at time of diagnostic evaluation? ○ Yes ○ No ○ Unknown

Race *(Check all that apply)*
☐ Caucasian ☐ Asian ☐ Other (Specify)
☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Unknown
☐ American Indian/Alaska Native

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

Country of Birth | If NOT United States, date of first U.S. arrival *(mm/dd/yyyy)* | Eligible for U.S Citizenship/Nationality at Birth (regardless of country of birth)? ○ Yes ○ No ○ Unknown

Country of Birth for Primary Guardian 1 *(patients <15 years old)* | Country of Birth for Primary Guardian 2 *(patients <15 years old)*

Country of Usual Residence | If Country of Usual Residence is NOT the U.S, has patient been in the U.S ≥ 90 days? ○ Yes ○ No ○ Unknown

Initial Evaluation

Status at Diagnosis of TB ○ Alive ○ Dead

Initial Reason Evaluated for TB Disease
○ Contact Investigation ○ Screening *(Immigration Medical Exam, Targeted Testing, Health Care Worker, Employment/Administrative Testing)*
○ TB Symptoms ○ Other *(Abnormal Chest Radiograph (consistent with TB), Incidental Lab Result)* ○ Unknown

DEMOGRAPHICS & INITIAL EVALUATION

Reporting Address

Date of Birth

Sex at Birth

Ethnicity

Race

Nativity

Country of Usual Residence

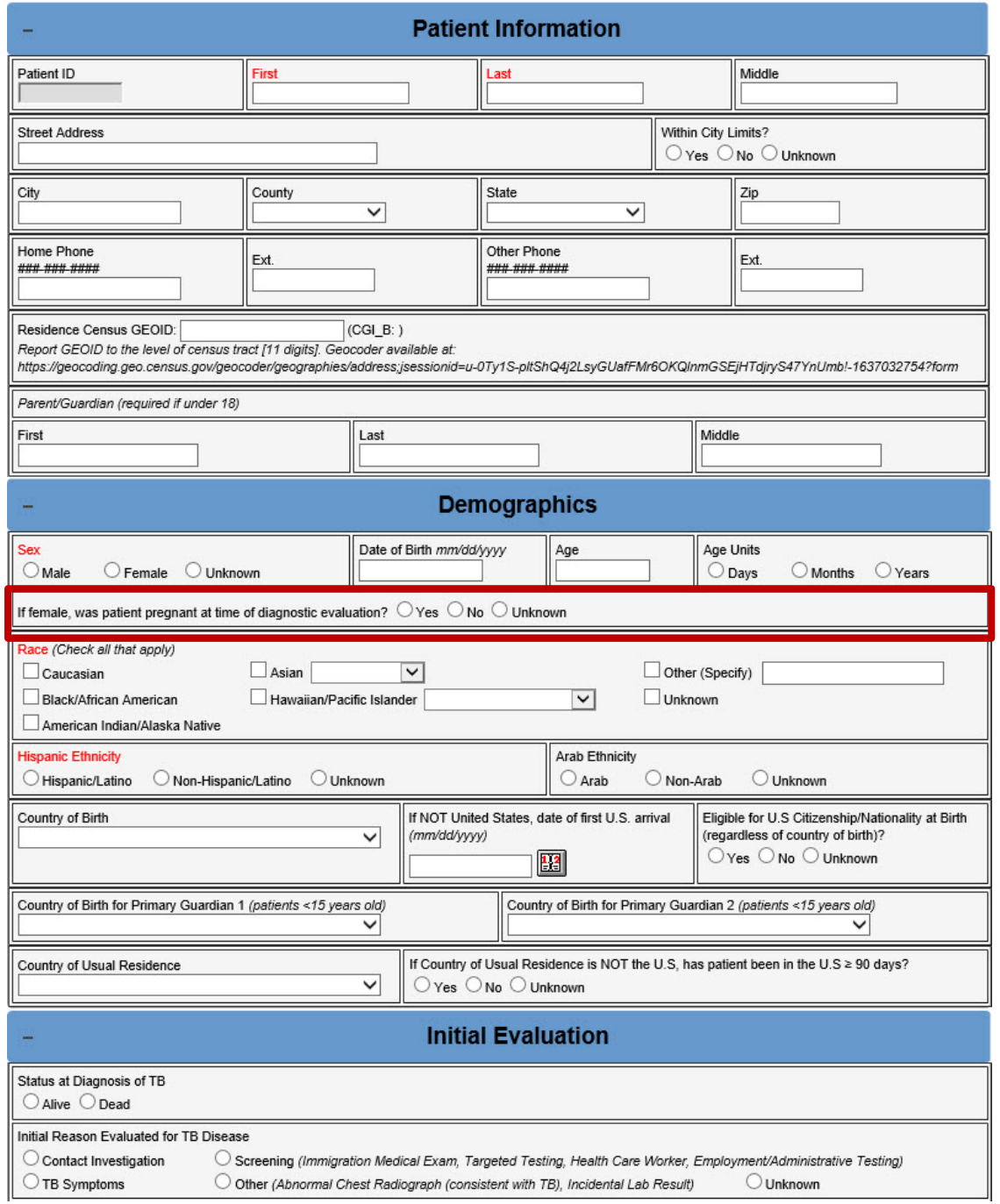
Status at TB Diagnosis

Initial Reason Evaluated for TB

Purpose: To establish the biological sex for the patient at birth for evaluation of epidemiologic trends

IF recorded female at birth, record if patient was pregnant when TB diagnostic evaluation was initiated.

2020 RVCT Reference Manual pg. 18



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.

Residence Census GEOID: (CGI_B:)
Report GEOID to the level of census tract [11 digits]. Geocoder available at:
https://geocoding.geo.census.gov/geocoder/geographies/address;jsessionid=u-0Ty1S-pltShQ4j2LsyGUafFMr6OKQlnmGSEjHTdjryS47YnUmb!-1637032754?form

Parent/Guardian (required if under 18)

First | Last | Middle

Demographics

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

If female, was patient pregnant at time of diagnostic evaluation? Yes No Unknown

Race *(Check all that apply)*
Caucasian | Asian | Other (Specify)
Black/African American | Hawaiian/Pacific Islander | Unknown
American Indian/Alaska Native

Hispanic Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unknown | Arab Ethnicity: Arab Non-Arab Unknown

Country of Birth | If NOT United States, date of first U.S. arrival *(mm/dd/yyyy)* | Eligible for U.S Citizenship/Nationality at Birth (regardless of country of birth)? Yes No Unknown

Country of Birth for Primary Guardian 1 *(patients <15 years old)* | Country of Birth for Primary Guardian 2 *(patients <15 years old)*

Country of Usual Residence | If Country of Usual Residence is NOT the U.S, has patient been in the U.S ≥ 90 days? Yes No Unknown

Initial Evaluation

Status at Diagnosis of TB: Alive Dead

Initial Reason Evaluated for TB Disease
Contact Investigation | Screening *(Immigration Medical Exam, Targeted Testing, Health Care Worker, Employment/Administrative Testing)*
TB Symptoms | Other *(Abnormal Chest Radiograph (consistent with TB), Incidental Lab Result)* | Unknown

DEMOGRAPHICS & INITIAL EVALUATION

Reporting Address

Date of Birth

Sex at Birth

Ethnicity

Race

Nativity

Country of Usual Residence

Status at TB Diagnosis

Initial Reason Evaluated for TB

Purpose: To establish the patient's ethnicity for evaluation of epidemiologic trends associated with ethnicity

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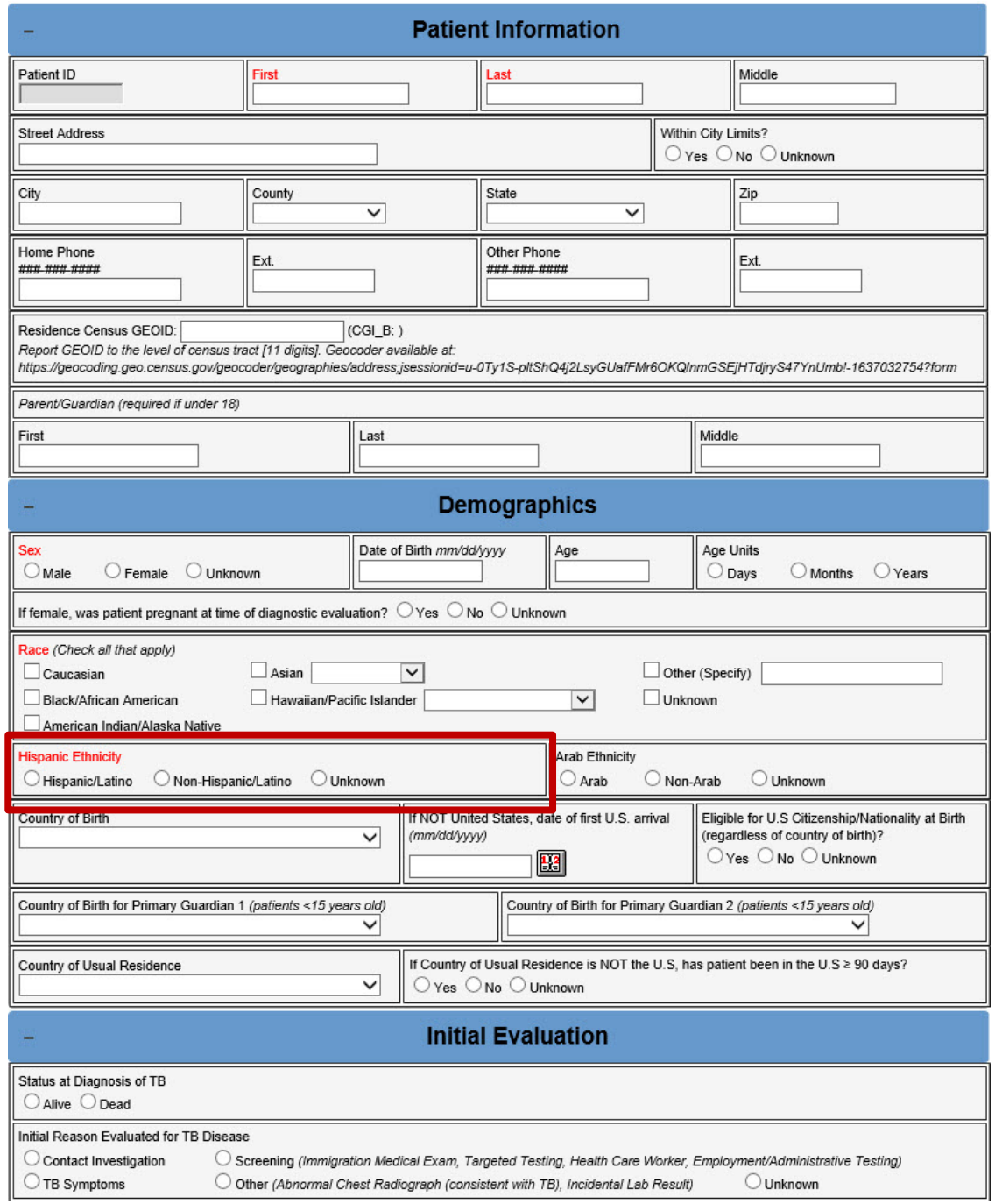


Patient Information

Patient ID | First | Last | Middle

Street Address | Within City Limits? Yes No Unknown

City | County | State | Zip

Home Phone ### ### #### | Ext. | Other Phone ### ### #### | Ext.

Residence Census GEOID: (CGI_B:)
Report GEOID to the level of census tract [11 digits]. Geocoder available at:
https://geocoding.geo.census.gov/geocoder/geographies/address;jsessionid=u-0Ty1S-pltShQ4j2LsyGUafFMr6OKQlnmGSEjHTdjryS47YnUmb!-1637032754?form

Parent/Guardian (required if under 18)

First | Last | Middle

Demographics

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

If female, was patient pregnant at time of diagnostic evaluation? Yes No Unknown

Race *(Check all that apply)*
Caucasian | Asian | Other (Specify)
Black/African American | Hawaiian/Pacific Islander | Unknown
American Indian/Alaska Native

Hispanic Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unknown

Arab Ethnicity: Arab Non-Arab Unknown

Country of Birth | If NOT United States, date of first U.S. arrival *(mm/dd/yyyy)* | Eligible for U.S Citizenship/Nationality at Birth (regardless of country of birth)? Yes No Unknown

Country of Birth for Primary Guardian 1 *(patients <15 years old)* | Country of Birth for Primary Guardian 2 *(patients <15 years old)*

Country of Usual Residence | If Country of Usual Residence is NOT the U.S, has patient been in the U.S ≥ 90 days? Yes No Unknown

Initial Evaluation

Status at Diagnosis of TB: Alive Dead

Initial Reason Evaluated for TB Disease
Contact Investigation | Screening *(Immigration Medical Exam, Targeted Testing, Health Care Worker, Employment/Administrative Testing)*
TB Symptoms | Other *(Abnormal Chest Radiograph (consistent with TB), Incidental Lab Result)* | Unknown

DEMOGRAPHICS & INITIAL EVALUATION

Reporting Address

Date of Birth

Sex at Birth

Ethnicity

Race

Nativity

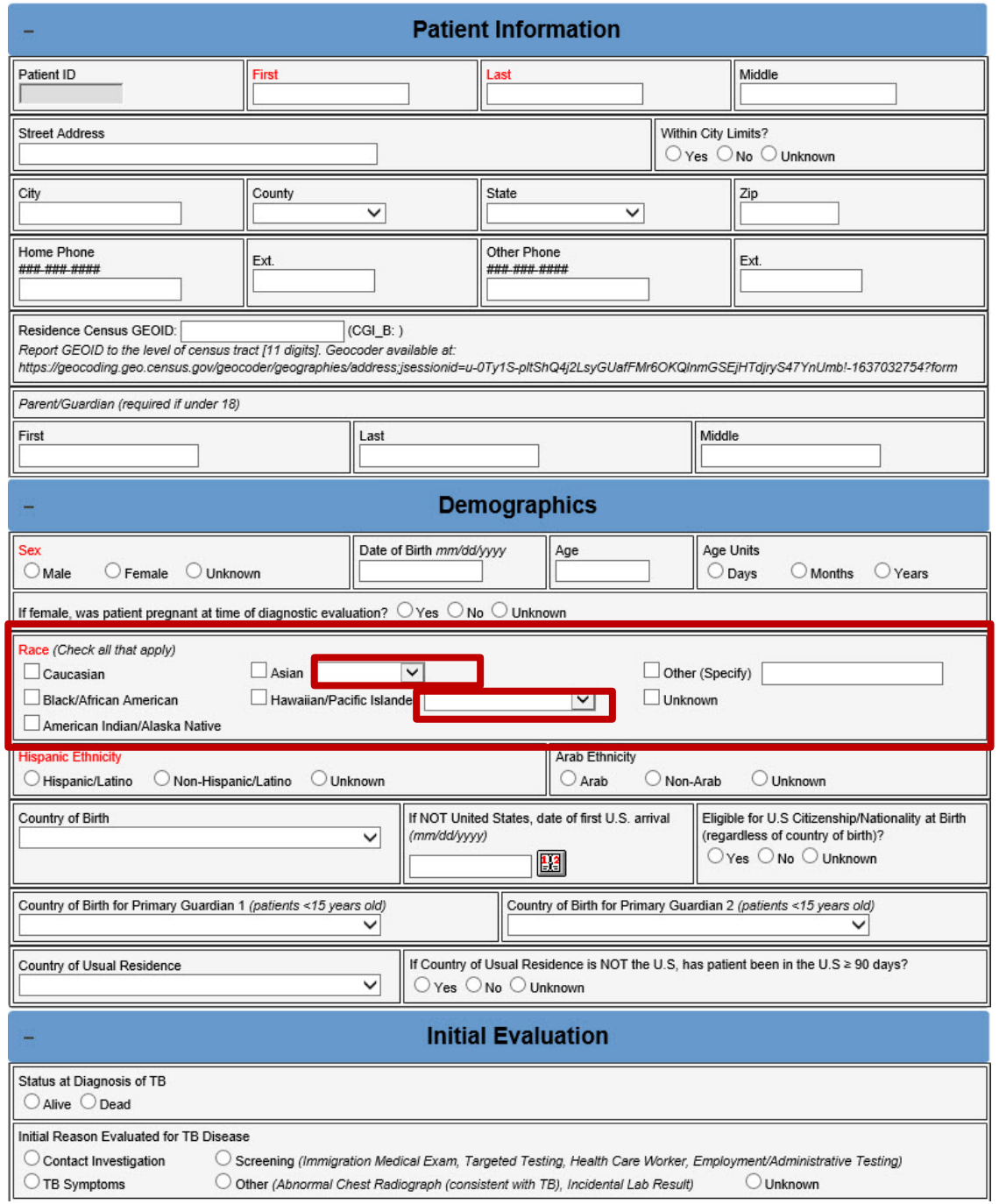
Country of Usual Residence

Status at TB Diagnosis

Initial Reason Evaluated for TB

Purpose: To establish the patient's race(s) for evaluation of epidemiologic trends associated with race.

2020 RVCT Reference Manual pg. 20-21



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.

Residence Census GEOID: (CGI_B:)
Report GEOID to the level of census tract [11 digits]. Geocoder available at:
https://geocoding.geo.census.gov/geocoder/geographies/address;jsessionid=u-0Ty1S-pltShQ4j2LsyGUafFMr6OKQlnmGSEjHTdjryS47YnUmb!-1637032754?form

Parent/Guardian (required if under 18)

First | Last | Middle

Demographics

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

If female, was patient pregnant at time of diagnostic evaluation? Yes No Unknown

Race *(Check all that apply)*
Caucasian | Asian | Other (Specify)
Black/African American | Hawaiian/Pacific Islande | Unknown
American Indian/Alaska Native

Hispanic Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unknown | Arab Ethnicity: Arab Non-Arab Unknown

Country of Birth | If NOT United States, date of first U.S. arrival *(mm/dd/yyyy)* | Eligible for U.S Citizenship/Nationality at Birth (regardless of country of birth)? Yes No Unknown

Country of Birth for Primary Guardian 1 *(patients <15 years old)* | Country of Birth for Primary Guardian 2 *(patients <15 years old)*

Country of Usual Residence | If Country of Usual Residence is NOT the U.S, has patient been in the U.S ≥ 90 days? Yes No Unknown

Initial Evaluation

Status at Diagnosis of TB: Alive Dead

Initial Reason Evaluated for TB Disease
Contact Investigation | Screening *(Immigration Medical Exam, Targeted Testing, Health Care Worker, Employment/Administrative Testing)*
TB Symptoms | Other *(Abnormal Chest Radiograph (consistent with TB), Incidental Lab Result)* | Unknown

National Electronic Disease Surveillance System (NEDSS)
Person Race Categories for Asian and for
Native Hawaiian or other Pacific Islander

Asian		Native Hawaiian or other Pacific Islander	
Asian Indian	Laotian	Carolinian	New Hebrides
Bangladeshi	Madagascar	Chamorro	Other Pacific Islander
Bhutanese	Malaysian	Chuukese	Palauan
Burmese	Maldivian	Fijian	Papua New Guinean
Cambodian	Nepalese	Guamanian	Pohnpeian
Chinese	Okinawan	Kiribati	Polynesian
Filipino	Pakistani	Kosraean	Saipanese
Hmong	Singaporean	Mariana Islander	Samoan
Indonesian	Sri Lankan	Marshallese	Solomon Islander
Iwo Jiman	Taiwanese	Melanesian	Tahitian
Japanese	Thai	Micronesian	Tokelauan
Korean	Vietnamese	Native Hawaiian	Tongan
			Yapese

DEMOGRAPHICS & INITIAL EVALUATION

Reporting Address

Date of Birth

Sex at Birth

Ethnicity

Race

Nativity

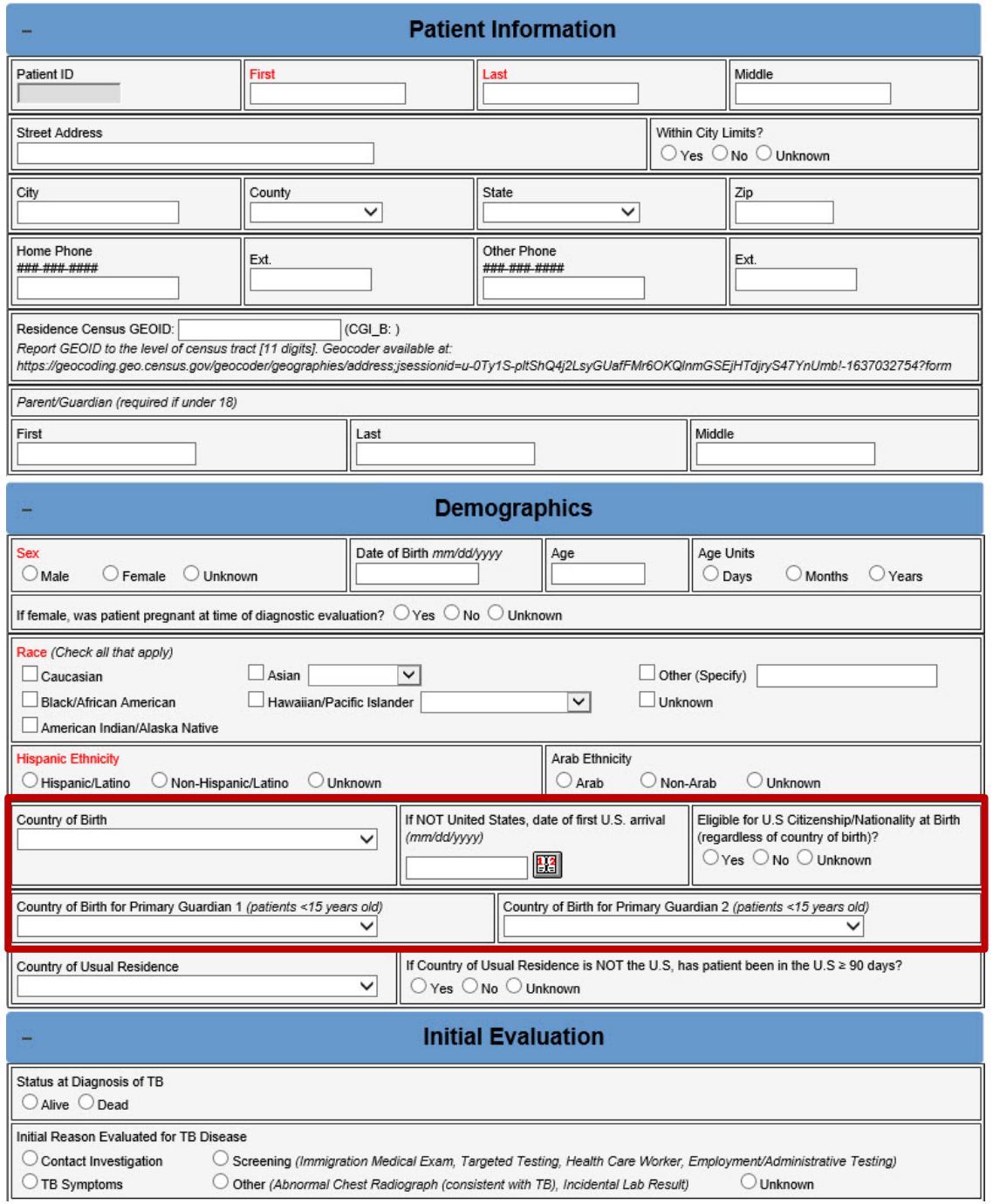
Country of Usual Residence

Status at TB Diagnosis

Initial Reason Evaluated for TB

Purpose: To establish the patient's country of birth and citizenship status at birth for evaluation of epidemiologic trends.

2020 RVCT Reference Manual pg. 22-23



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.

Residence Census GEOID: (CGI_B:)
Report GEOID to the level of census tract [11 digits]. Geocoder available at:
https://geocoding.geo.census.gov/geocoder/geographies/address;jsessionid=u-0Ty1S-pltShQ4j2LsyGUafFMr6OKQlnmGSEjHTdjryS47YnUmb!-1637032754?form

Parent/Guardian (required if under 18)

First | Last | Middle

Demographics

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

If female, was patient pregnant at time of diagnostic evaluation? Yes No Unknown

Race *(Check all that apply)*
Caucasian | Asian | Other (Specify)
Black/African American | Hawaiian/Pacific Islander | Unknown
American Indian/Alaska Native

Hispanic Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unknown | Arab Ethnicity: Arab Non-Arab Unknown

Country of Birth | If NOT United States, date of first U.S. arrival *(mm/dd/yyyy)* | Eligible for U.S Citizenship/Nationality at Birth (regardless of country of birth)? Yes No Unknown

Country of Birth for Primary Guardian 1 *(patients <15 years old)* | Country of Birth for Primary Guardian 2 *(patients <15 years old)*

Country of Usual Residence | If Country of Usual Residence is NOT the U.S, has patient been in the U.S ≥ 90 days? Yes No Unknown

Initial Evaluation

Status at Diagnosis of TB: Alive Dead

Initial Reason Evaluated for TB Disease
Contact Investigation | Screening *(Immigration Medical Exam, Targeted Testing, Health Care Worker, Employment/Administrative Testing)*
TB Symptoms | Other *(Abnormal Chest Radiograph (consistent with TB), Incidental Lab Result)* | Unknown

DEMOGRAPHICS & INITIAL EVALUATION

Reporting Address

Date of Birth

Sex at Birth

Ethnicity

Race

Nativity

Country of Usual Residence

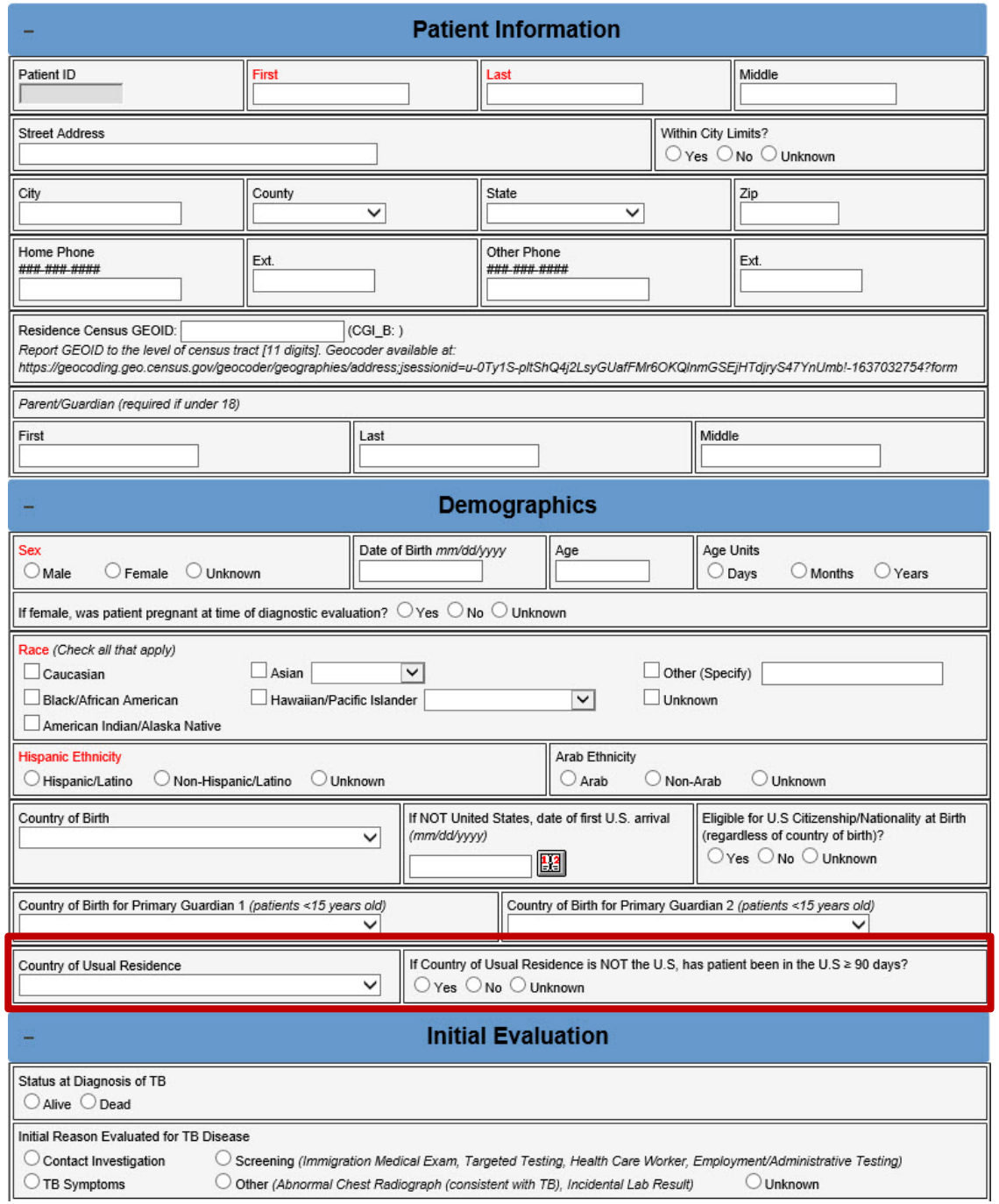
Status at TB Diagnosis

Initial Reason Evaluated for TB

Country where the patient **usually** resides.

Purpose: To determine whether a patient was a resident of the United States at the time of diagnosis.

2020 RVCT Reference Manual pg. 24



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.

Residence Census GEOID: (CGI_B:)
Report GEOID to the level of census tract [11 digits]. Geocoder available at:
https://geocoding.geo.census.gov/geocoder/geographies/address;jsessionid=u-0Ty1S-pltShQ4j2LsyGUafFMr6OKQlnmGSEjHTdjryS47YnUmb!-1637032754?form

Parent/Guardian (required if under 18)

First | Last | Middle

Demographics

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

If female, was patient pregnant at time of diagnostic evaluation? Yes No Unknown

Race *(Check all that apply)*
Caucasian | Asian | Other (Specify)
Black/African American | Hawaiian/Pacific Islander | Unknown
American Indian/Alaska Native

Hispanic Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unknown | Arab Ethnicity: Arab Non-Arab Unknown

Country of Birth | If NOT United States, date of first U.S. arrival *(mm/dd/yyyy)* | Eligible for U.S Citizenship/Nationality at Birth (regardless of country of birth)? Yes No Unknown

Country of Birth for Primary Guardian 1 *(patients <15 years old)* | Country of Birth for Primary Guardian 2 *(patients <15 years old)*

Country of Usual Residence | If Country of Usual Residence is NOT the U.S, has patient been in the U.S ≥ 90 days? Yes No Unknown

Initial Evaluation

Status at Diagnosis of TB: Alive Dead

Initial Reason Evaluated for TB Disease
Contact Investigation | Screening *(Immigration Medical Exam, Targeted Testing, Health Care Worker, Employment/Administrative Testing)*
TB Symptoms | Other *(Abnormal Chest Radiograph (consistent with TB), Incidental Lab Result)* | Unknown

DEMOGRAPHICS & INITIAL EVALUATION

Reporting Address

Date of Birth

Sex at Birth

Ethnicity

Race

Nativity

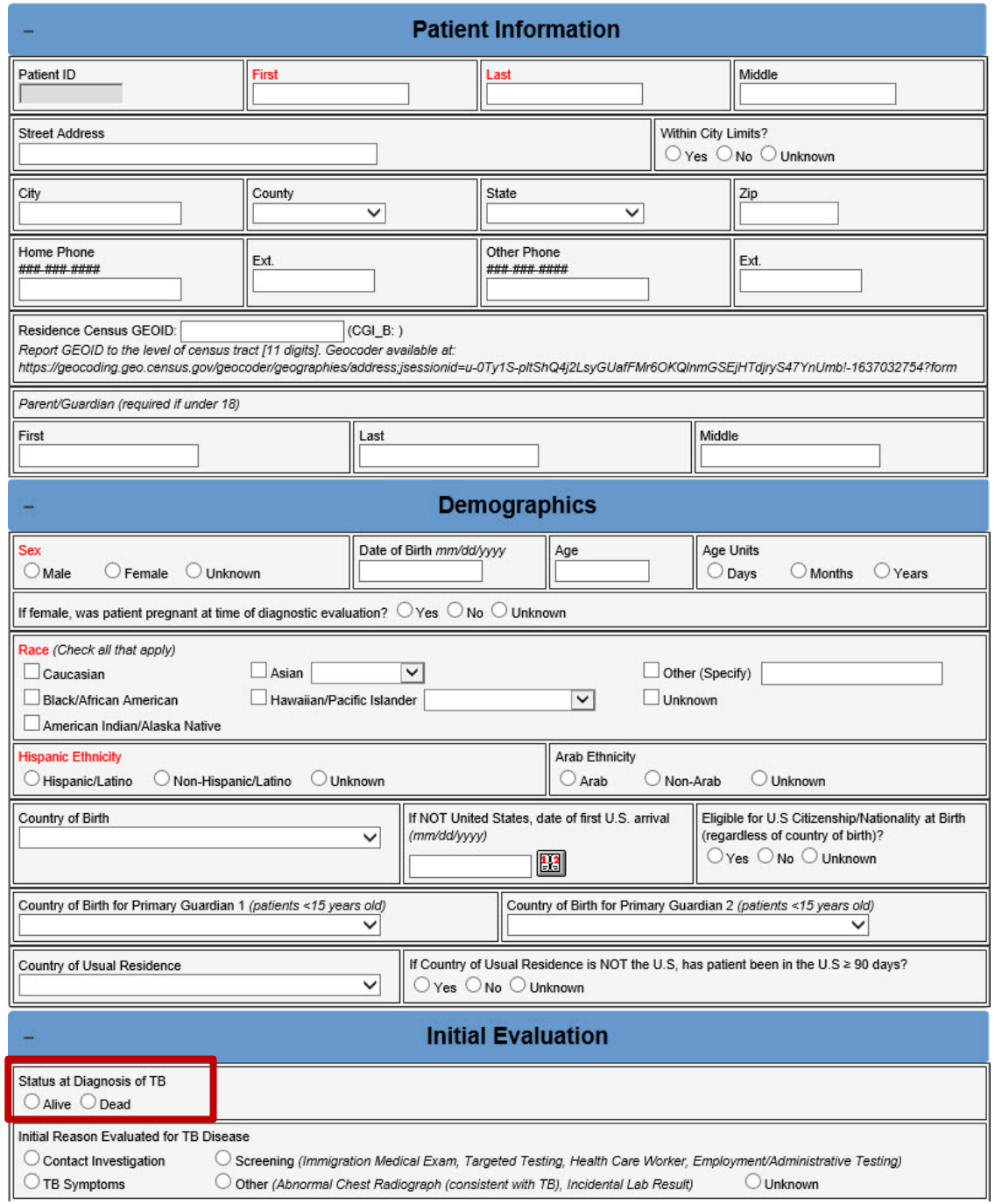
Country of Usual Residence

Status at TB Diagnosis

Initial Reason Evaluated for TB

Purpose: To determine if the patient was alive at the time of TB diagnosis

2020 RVCT Reference Manual pg. 25



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.

Residence Census GEOID: (CGI_B:)
Report GEOID to the level of census tract [11 digits]. Geocoder available at:
https://geocoding.geo.census.gov/geocoder/geographies/address;jsessionid=u-0Ty1S-pltShQ4j2LsyGUafFMr6OKQlnmGSEjHTdjryS47YnUmb!-1637032754?form

Parent/Guardian (required if under 18)

First | Last | Middle

Demographics

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

If female, was patient pregnant at time of diagnostic evaluation? Yes No Unknown

Race *(Check all that apply)*
Caucasian | Asian | Other (Specify)
Black/African American | Hawaiian/Pacific Islander | Unknown
American Indian/Alaska Native

Hispanic Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unknown | Arab Ethnicity: Arab Non-Arab Unknown

Country of Birth | If NOT United States, date of first U.S. arrival *(mm/dd/yyyy)* | Eligible for U.S Citizenship/Nationality at Birth (regardless of country of birth)? Yes No Unknown

Country of Birth for Primary Guardian 1 *(patients <15 years old)* | Country of Birth for Primary Guardian 2 *(patients <15 years old)*

Country of Usual Residence | If Country of Usual Residence is NOT the U.S, has patient been in the U.S ≥ 90 days? Yes No Unknown

Initial Evaluation

Status at Diagnosis of TB: Alive Dead

Initial Reason Evaluated for TB Disease
Contact Investigation | Screening *(Immigration Medical Exam, Targeted Testing, Health Care Worker, Employment/Administrative Testing)*
TB Symptoms | Other *(Abnormal Chest Radiograph (consistent with TB), Incidental Lab Result)* | Unknown

DEMOGRAPHICS & INITIAL EVALUATION

Reporting Address

Date of Birth

Sex at Birth

Ethnicity

Race

Nativity

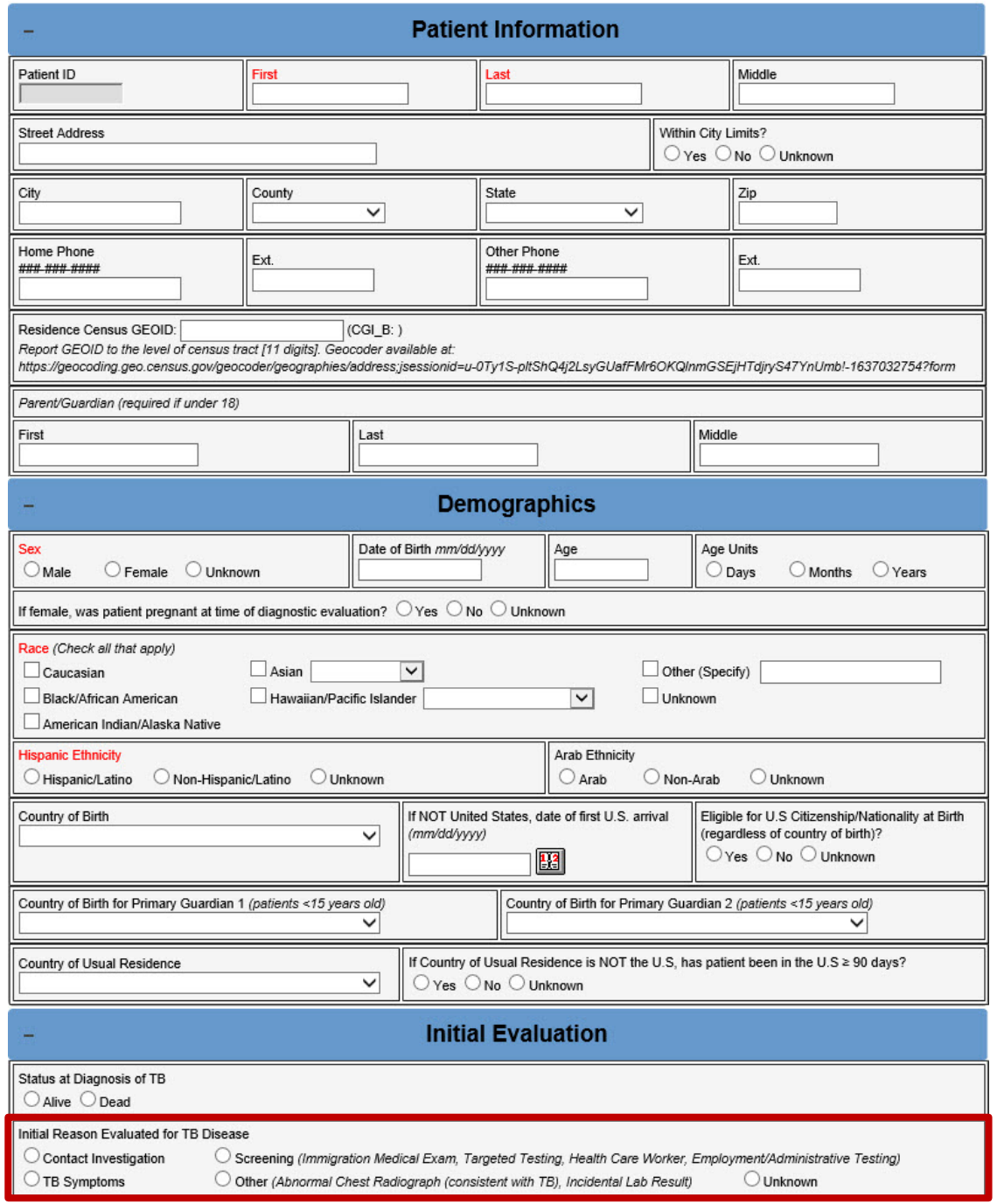
Country of Usual Residence

Status at TB Diagnosis

Initial Reason Evaluated for TB

Purpose: To ascertain trends in how TB cases came to the attention of the medical or public health establishment

2020 RVCT Reference Manual pg. 26



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.

Residence Census GEOID: (CGI_B:)
Report GEOID to the level of census tract [11 digits]. Geocoder available at:
https://geocoding.geo.census.gov/geocoder/geographies/address;jsessionid=u-0Ty1S-pltShQ4j2LsyGUafFMr6OKQlnmGSEjHTdjryS47YnUmb!-1637032754?form

Parent/Guardian (required if under 18)

First | Last | Middle

Demographics

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

If female, was patient pregnant at time of diagnostic evaluation? Yes No Unknown

Race *(Check all that apply)*
Caucasian | Asian | Other (Specify)
Black/African American | Hawaiian/Pacific Islander | Unknown
American Indian/Alaska Native

Hispanic Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unknown | Arab Ethnicity: Arab Non-Arab Unknown

Country of Birth | If NOT United States, date of first U.S. arrival *(mm/dd/yyyy)* | Eligible for U.S Citizenship/Nationality at Birth (regardless of country of birth)? Yes No Unknown

Country of Birth for Primary Guardian 1 *(patients <15 years old)* | Country of Birth for Primary Guardian 2 *(patients <15 years old)*

Country of Usual Residence | If Country of Usual Residence is NOT the U.S, has patient been in the U.S ≥ 90 days? Yes No Unknown

Initial Evaluation

Status at Diagnosis of TB: Alive Dead

Initial Reason Evaluated for TB Disease
Contact Investigation | Screening *(Immigration Medical Exam, Targeted Testing, Health Care Worker, Employment/Administrative Testing)*
TB Symptoms | Other *(Abnormal Chest Radiograph (consistent with TB), Incidental Lab Result)* | Unknown

Patient Information

Patient ID	First	Last	Middle
15094199577	SHONA	SMITH	R

Street Address	Within City Limits?
333 S GRAND AVE	(•) Yes ( ) No ( ) Unknown

City	County	State	Zip
LANSING	Ingham	Michigan	48933

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

Residence Census GEOID: 260650067001018 (CGI_B: 26065006700)

Report GEOID to the level of census tract [11 digits]. Geocoder available at:
https://geocoding.geo.census.gov/geocoder/geographies/address;jsessionid=u-0Ty1S-pltShQ4j2LsyGUafFMr6OKQlnmGSEjHTdjryS47YnUmb!-1637032754?form

Parent/Guardian (required if under 18)

First	Last	Middle

Demographics

Sex
○ Male ◉ Female ○ Unknown

Date of Birth *mm/dd/yyyy*
12/14/1986

Age
33

Age Units
○ Days ○ Months ◉ Years

If female, was patient pregnant at time of diagnostic evaluation? ○ Yes ◉ No ○ Unknown

Race *(Check all that apply)*
☑ Caucasian
☐ Asian
☐ Black/African American
☐ Hawaiian/Pacific Islander
☐ American Indian/Alaska Native
☐ Other (Specify)
☐ Unknown

Hispanic Ethnicity
○ Hispanic/Latino ◉ Non-Hispanic/Latino ○ Unknown

Arab Ethnicity
○ Arab ◉ Non-Arab ○ Unknown

Country of Birth
UNITED STATES

If NOT United States, date of first U.S. arrival *(mm/dd/yyyy)*

Eligible for U.S Citizenship/Nationality at Birth (regardless of country of birth)?
◉ Yes ○ No ○ Unknown

Country of Birth for Primary Guardian 1 *(patients <15 years old)*

Country of Birth for Primary Guardian 2 *(patients <15 years old)*

Country of Usual Residence
UNITED STATES

If Country of Usual Residence is NOT the U.S, has patient been in the U.S ≥ 90 days?
○ Yes ○ No ○ Unknown

Initial Evaluation

Status at Diagnosis of TB
◉ Alive ○ Dead

Initial Reason Evaluated for TB Disease
○ Contact Investigation
○ Screening *(Immigration Medical Exam, Targeted Testing, Health Care Worker, Employment/Administrative Testing)*
◉ TB Symptoms
○ Other *(Abnormal Chest Radiograph (consistent with TB), Incidental Lab Result)*
○ Unknown

RISK FACTORS

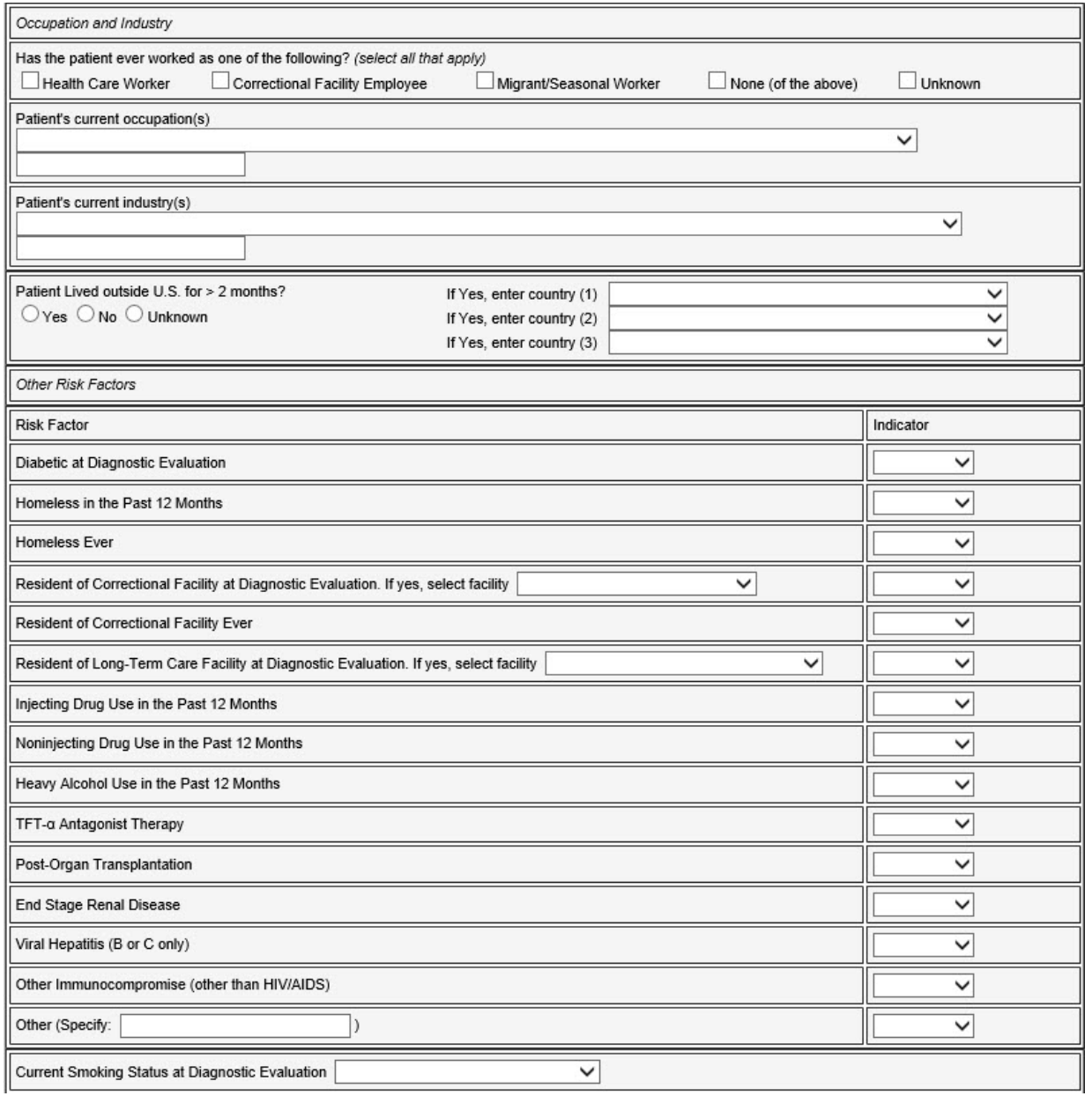
Occupation and Industry

Lived outside the United States for >2 months (uninterrupted)?

Other Risk Factors

- If Resident of Correctional Facility at Diagnostic Evaluation, Type of Facility?
- If Resident of Long-Term Care Facility at Diagnostic Evaluation, Type of Facility?

Current Smoking Status at Diagnostic Evaluation



Occupation and Industry

Has the patient ever worked as one of the following? *(select all that apply)*

☐ Health Care Worker ☐ Correctional Facility Employee ☐ Migrant/Seasonal Worker ☐ None (of the above) ☐ Unknown

Patient's current occupation(s)

Patient's current industry(s)

Patient Lived outside U.S. for > 2 months?

○ Yes ○ No ○ Unknown

If Yes, enter country (1)

If Yes, enter country (2)

If Yes, enter country (3)

Other Risk Factors

Risk Factor	Indicator
Diabetic at Diagnostic Evaluation	
Homeless in the Past 12 Months	
Homeless Ever	
Resident of Correctional Facility at Diagnostic Evaluation. If yes, select facility	
Resident of Correctional Facility Ever	
Resident of Long-Term Care Facility at Diagnostic Evaluation. If yes, select facility	
Injecting Drug Use in the Past 12 Months	
Noninjecting Drug Use in the Past 12 Months	
Heavy Alcohol Use in the Past 12 Months	
TFT-α Antagonist Therapy	
Post-Organ Transplantation	
End Stage Renal Disease	
Viral Hepatitis (B or C only)	
Other Immunocompromise (other than HIV/AIDS)	
Other (Specify:)	

Current Smoking Status at Diagnostic Evaluation

RISK FACTORS

Occupation and Industry

Lived outside the United States for >2 months (uninterrupted)?

Other Risk Factors

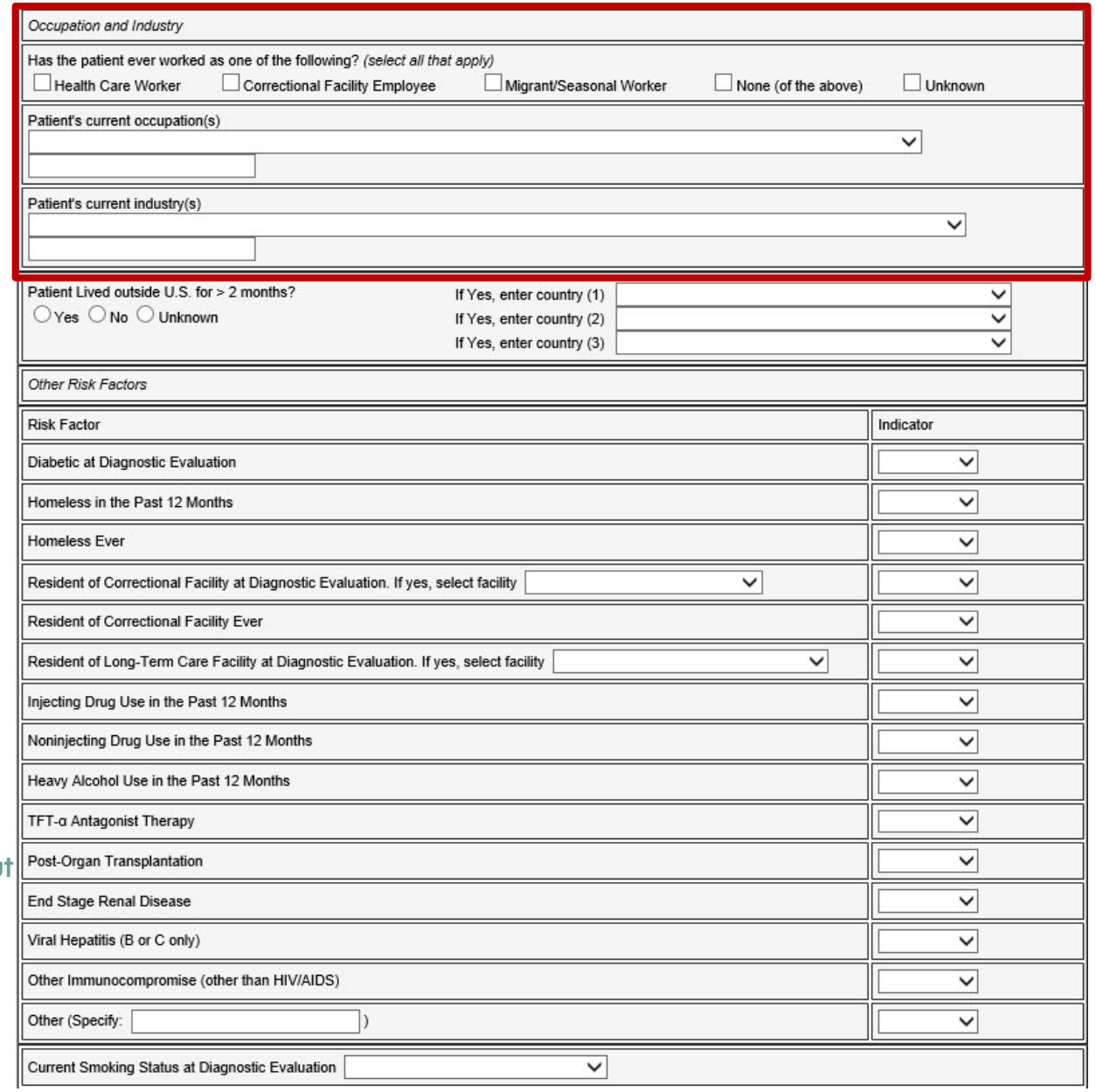
- If Resident of Correctional Facility at Diagnostic Evaluation, Type of Facility?
- If Resident of Long-Term Care Facility at Diagnostic Evaluation, Type of Facility?

Current Smoking Status at Diagnostic Evaluation

Purpose: To evaluate potential associations between workplace exposures and TB by collecting information about the person's current occupations and industries.

You only need to type into text box. You do not need to select the drop-downs.

2020 RVCT Reference Manual pg. 27-29



Occupation and Industry

Has the patient ever worked as one of the following? *(select all that apply)*

☐ Health Care Worker ☐ Correctional Facility Employee ☐ Migrant/Seasonal Worker ☐ None (of the above) ☐ Unknown

Patient's current occupation(s)

Patient's current industry(s)

Patient Lived outside U.S. for > 2 months?

○ Yes ○ No ○ Unknown

If Yes, enter country (1)

If Yes, enter country (2)

If Yes, enter country (3)

Other Risk Factors

Risk Factor	Indicator
Diabetic at Diagnostic Evaluation	
Homeless in the Past 12 Months	
Homeless Ever	
Resident of Correctional Facility at Diagnostic Evaluation. If yes, select facility	
Resident of Correctional Facility Ever	
Resident of Long-Term Care Facility at Diagnostic Evaluation. If yes, select facility	
Injecting Drug Use in the Past 12 Months	
Noninjecting Drug Use in the Past 12 Months	
Heavy Alcohol Use in the Past 12 Months	
TFT-α Antagonist Therapy	
Post-Organ Transplantation	
End Stage Renal Disease	
Viral Hepatitis (B or C only)	
Other Immunocompromise (other than HIV/AIDS)	
Other (Specify:)	

Current Smoking Status at Diagnostic Evaluation

RISK FACTORS

Occupation and Industry

Lived outside the United States for >2 months (uninterrupted)?

Other Risk Factors

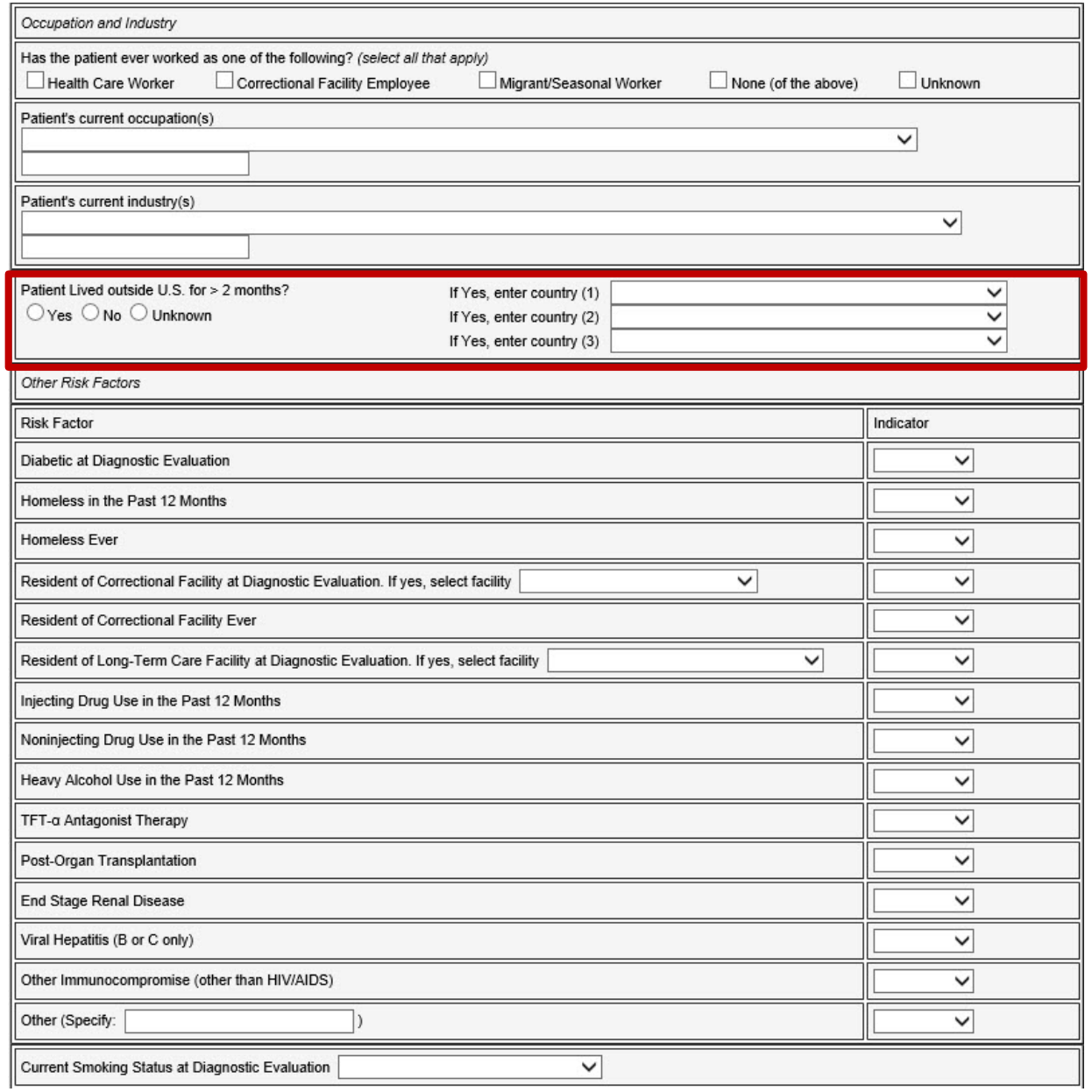
- If Resident of Correctional Facility at Diagnostic Evaluation, Type of Facility?
- If Resident of Long-Term Care Facility at Diagnostic Evaluation, Type of Facility?

Current Smoking Status at Diagnostic Evaluation

Indicate if patient resided or traveled outside the U.S. for 2 or more months, uninterrupted.

Purpose: To determine the extent to which persons with TB have traveled to countries that might pose a higher risk of TB exposure

2020 RVCT Reference Manual pg. 37



Occupation and Industry

Has the patient ever worked as one of the following? *(select all that apply)*

☐ Health Care Worker ☐ Correctional Facility Employee ☐ Migrant/Seasonal Worker ☐ None (of the above) ☐ Unknown

Patient's current occupation(s)

Patient's current industry(s)

Patient Lived outside U.S. for > 2 months?

○ Yes ○ No ○ Unknown

If Yes, enter country (1)

If Yes, enter country (2)

If Yes, enter country (3)

Other Risk Factors

Risk Factor	Indicator
Diabetic at Diagnostic Evaluation	
Homeless in the Past 12 Months	
Homeless Ever	
Resident of Correctional Facility at Diagnostic Evaluation. If yes, select facility	
Resident of Correctional Facility Ever	
Resident of Long-Term Care Facility at Diagnostic Evaluation. If yes, select facility	
Injecting Drug Use in the Past 12 Months	
Noninjecting Drug Use in the Past 12 Months	
Heavy Alcohol Use in the Past 12 Months	
TFT-α Antagonist Therapy	
Post-Organ Transplantation	
End Stage Renal Disease	
Viral Hepatitis (B or C only)	
Other Immunocompromise (other than HIV/AIDS)	
Other (Specify:)	

Current Smoking Status at Diagnostic Evaluation

RISK FACTORS

Occupation and Industry

Lived outside the United States for >2 months (uninterrupted)?

Other Risk Factors

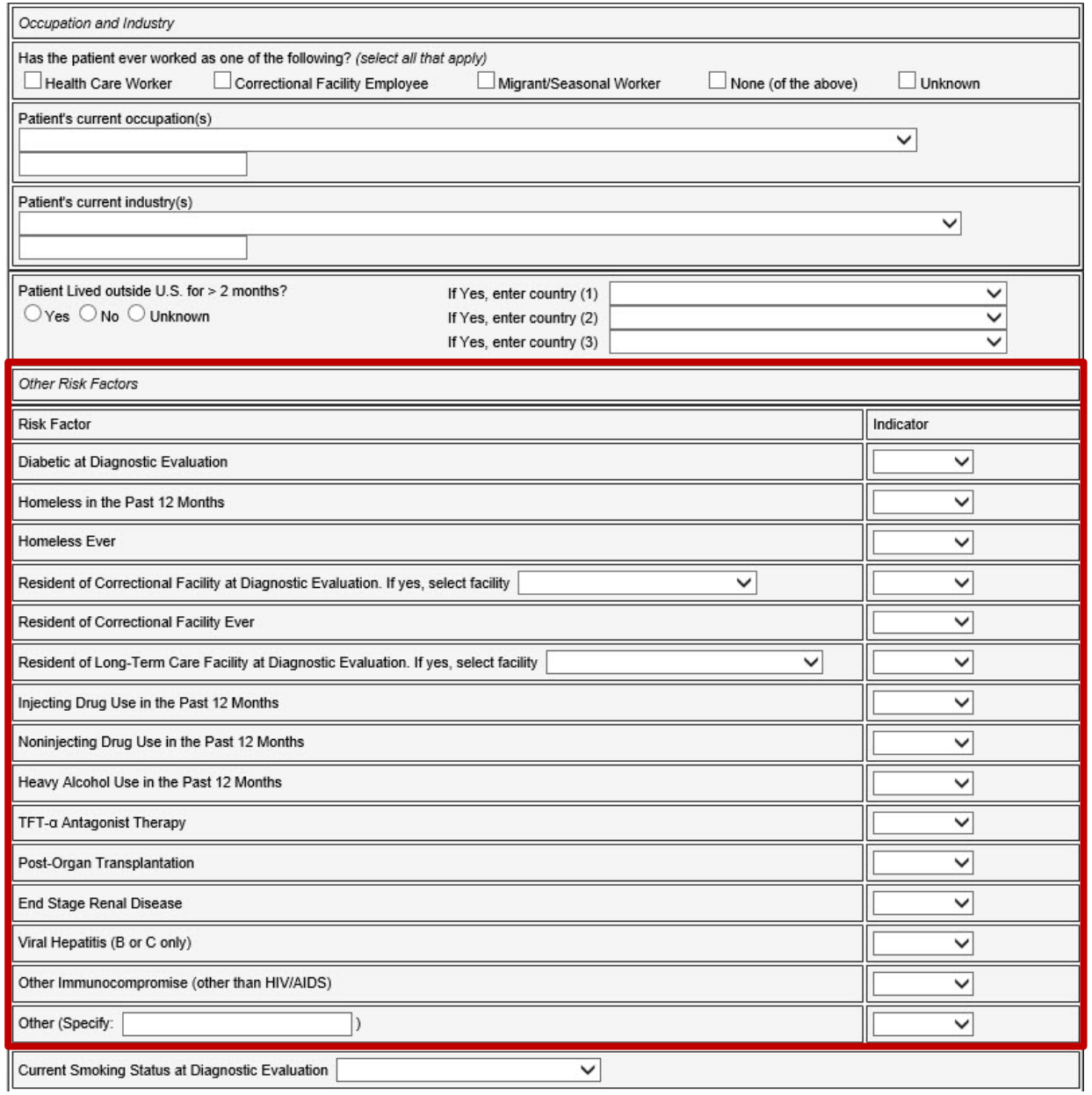
- If Resident of Correctional Facility at Diagnostic Evaluation, Type of Facility?
- If Resident of Long-Term Care Facility at Diagnostic Evaluation, Type of Facility?

Current Smoking Status at Diagnostic Evaluation

Indicate whether patient has one or more of the listed risk factors.

Purpose: To evaluate potential risk factors for TB disease

2020 RVCT Reference Manual pg. 30-32



Occupation and Industry

Has the patient ever worked as one of the following? *(select all that apply)*

☐ Health Care Worker ☐ Correctional Facility Employee ☐ Migrant/Seasonal Worker ☐ None (of the above) ☐ Unknown

Patient's current occupation(s)

Patient's current industry(s)

Patient Lived outside U.S. for > 2 months?

○ Yes ○ No ○ Unknown

If Yes, enter country (1)

If Yes, enter country (2)

If Yes, enter country (3)

Other Risk Factors

Risk Factor	Indicator
Diabetic at Diagnostic Evaluation	
Homeless in the Past 12 Months	
Homeless Ever	
Resident of Correctional Facility at Diagnostic Evaluation. If yes, select facility	
Resident of Correctional Facility Ever	
Resident of Long-Term Care Facility at Diagnostic Evaluation. If yes, select facility	
Injecting Drug Use in the Past 12 Months	
Noninjecting Drug Use in the Past 12 Months	
Heavy Alcohol Use in the Past 12 Months	
TFT-α Antagonist Therapy	
Post-Organ Transplantation	
End Stage Renal Disease	
Viral Hepatitis (B or C only)	
Other Immunocompromise (other than HIV/AIDS)	
Other (Specify:)	

Current Smoking Status at Diagnostic Evaluation

RISK FACTORS

Occupation and Industry

Lived outside the United States for >2 months (uninterrupted)?

Other Risk Factors

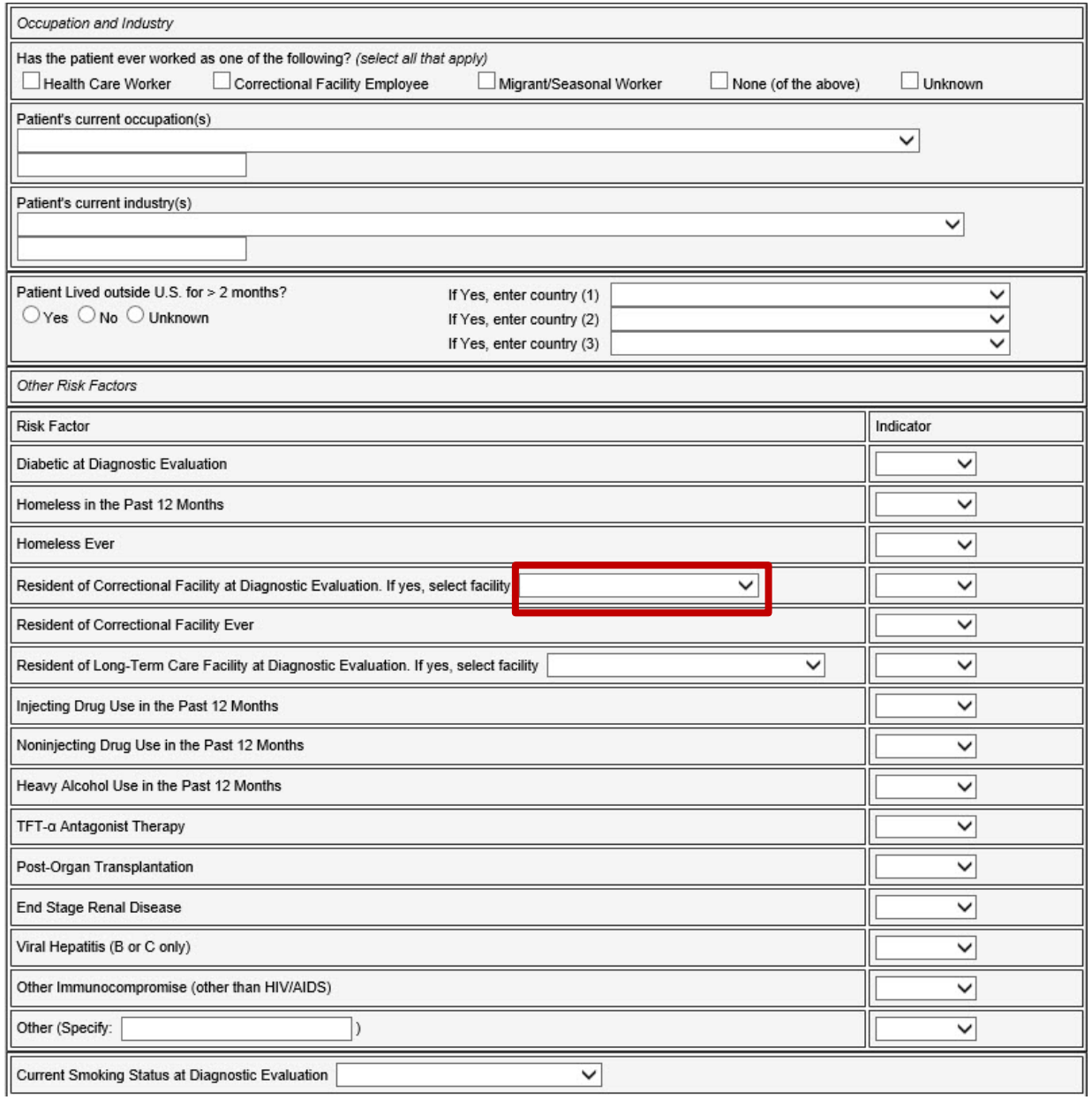
- If Resident of Correctional Facility at Diagnostic Evaluation, Type of Facility?
- If Resident of Long-Term Care Facility at Diagnostic Evaluation, Type of Facility?

Current Smoking Status at Diagnostic Evaluation

Specify whether the case

Purpose: To categorize the type of correctional facility for those patients who were residing in a correctional facility at the time of diagnostic evaluation.

2020 RVCT Reference Manual pg. 33



Occupation and Industry

Has the patient ever worked as one of the following? *(select all that apply)*

☐ Health Care Worker ☐ Correctional Facility Employee ☐ Migrant/Seasonal Worker ☐ None (of the above) ☐ Unknown

Patient's current occupation(s)

Patient's current industry(s)

Patient Lived outside U.S. for > 2 months?

○ Yes ○ No ○ Unknown

If Yes, enter country (1)

If Yes, enter country (2)

If Yes, enter country (3)

Other Risk Factors

Risk Factor	Indicator
Diabetic at Diagnostic Evaluation	
Homeless in the Past 12 Months	
Homeless Ever	
Resident of Correctional Facility at Diagnostic Evaluation. If yes, select facility	
Resident of Correctional Facility Ever	
Resident of Long-Term Care Facility at Diagnostic Evaluation. If yes, select facility	
Injecting Drug Use in the Past 12 Months	
Noninjecting Drug Use in the Past 12 Months	
Heavy Alcohol Use in the Past 12 Months	
TFT-α Antagonist Therapy	
Post-Organ Transplantation	
End Stage Renal Disease	
Viral Hepatitis (B or C only)	
Other Immunocompromise (other than HIV/AIDS)	
Other (Specify:)	

Current Smoking Status at Diagnostic Evaluation

RISK FACTORS

Occupation and Industry

Lived outside the United States for >2 months (uninterrupted)?

Other Risk Factors

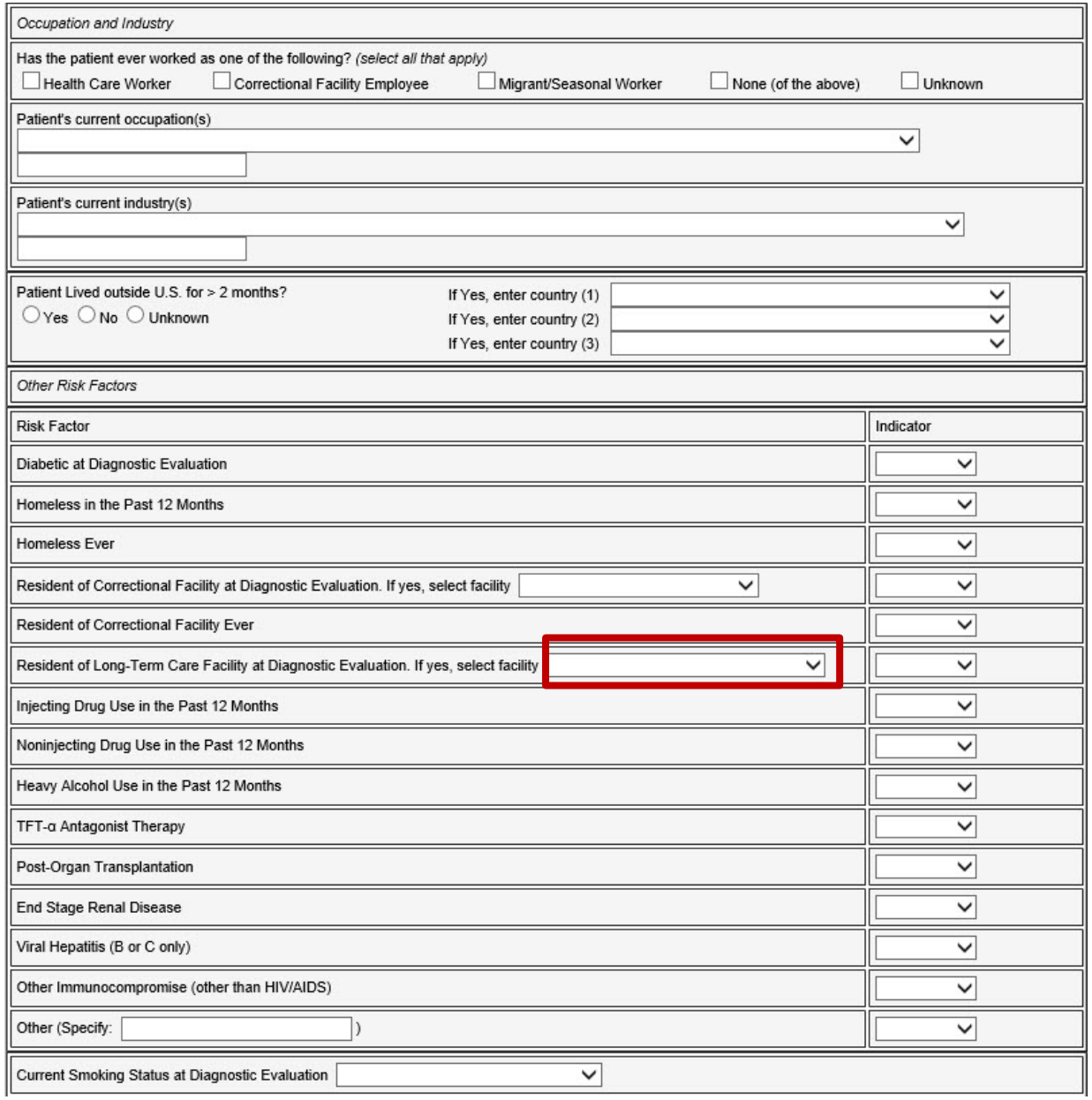
- If Resident of Correctional Facility at Diagnostic Evaluation, Type of Facility?
- If Resident of Long-Term Care Facility at Diagnostic Evaluation, Type of Facility?

Current Smoking Status at Diagnostic Evaluation

Specify whether the case

Purpose: To categorize the type of long-term care facility for those patients who were residing in a long-term care facility at the time of diagnostic evaluation.

2020 RVCT Reference Manual pg. 34-35



Occupation and Industry

Has the patient ever worked as one of the following? *(select all that apply)*

☐ Health Care Worker ☐ Correctional Facility Employee ☐ Migrant/Seasonal Worker ☐ None (of the above) ☐ Unknown

Patient's current occupation(s)

Patient's current industry(s)

Patient Lived outside U.S. for > 2 months?

○ Yes ○ No ○ Unknown

If Yes, enter country (1)

If Yes, enter country (2)

If Yes, enter country (3)

Other Risk Factors

Risk Factor	Indicator
Diabetic at Diagnostic Evaluation	
Homeless in the Past 12 Months	
Homeless Ever	
Resident of Correctional Facility at Diagnostic Evaluation. If yes, select facility	
Resident of Correctional Facility Ever	
Resident of Long-Term Care Facility at Diagnostic Evaluation. If yes, select facility	
Injecting Drug Use in the Past 12 Months	
Noninjecting Drug Use in the Past 12 Months	
Heavy Alcohol Use in the Past 12 Months	
TFT-α Antagonist Therapy	
Post-Organ Transplantation	
End Stage Renal Disease	
Viral Hepatitis (B or C only)	
Other Immunocompromise (other than HIV/AIDS)	
Other (Specify:)	

Current Smoking Status at Diagnostic Evaluation

RISK FACTORS

Occupation and Industry

Lived outside the United States for >2 months (uninterrupted)?

Other Risk Factors

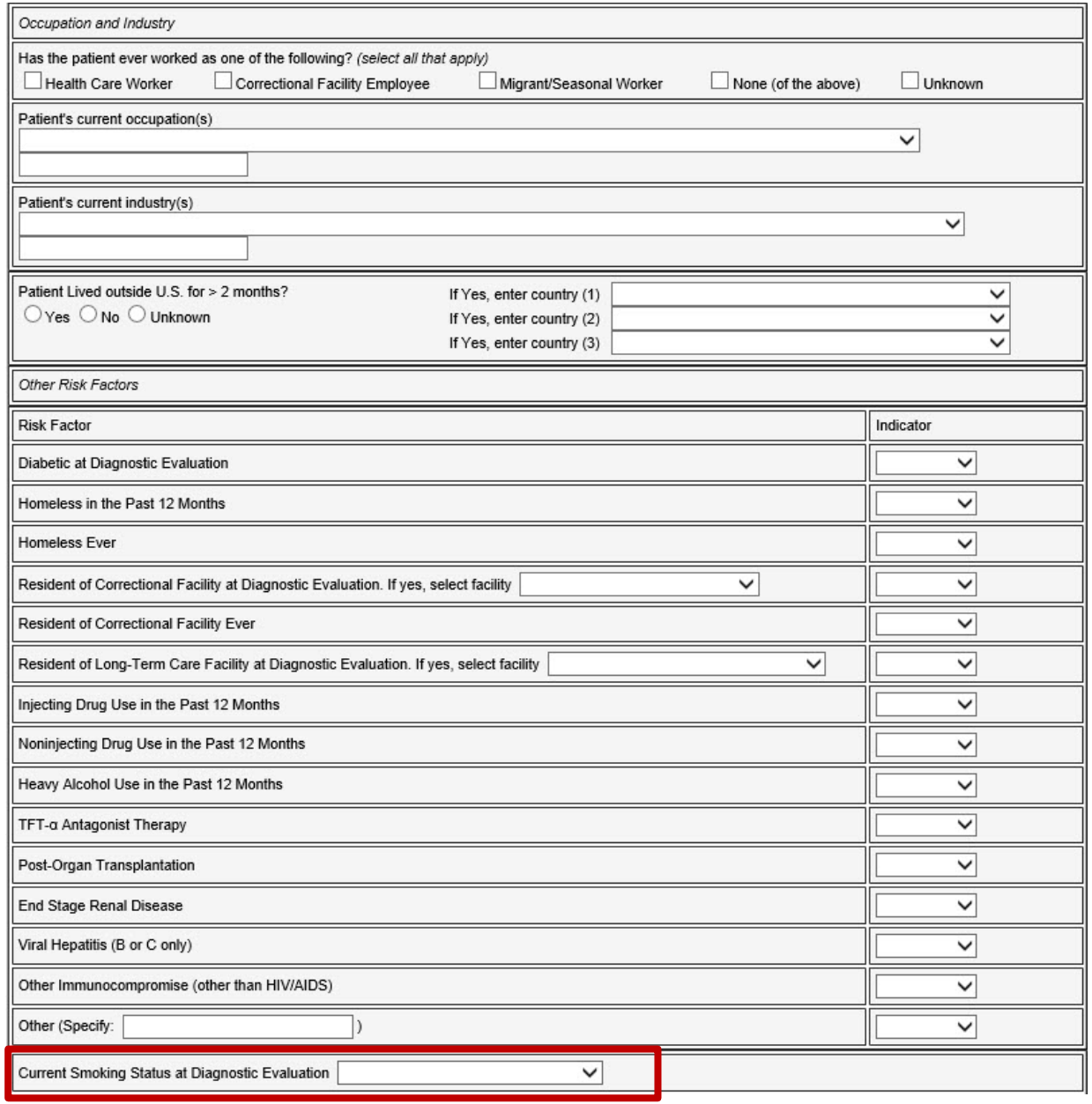
- If Resident of Correctional Facility at Diagnostic Evaluation, Type of Facility?
- If Resident of Long-Term Care Facility at Diagnostic Evaluation, Type of Facility?

Current Smoking Status at Diagnostic Evaluation

Indicate whether patient is current, former, or never smoker. If current, indicate frequency.

Purpose: Surveillance and patient management. To assess factors that may complicate testing, treatment, and follow-up.

2020 RVCT Reference Manual pg. 36



Occupation and Industry

Has the patient ever worked as one of the following? *(select all that apply)*

☐ Health Care Worker ☐ Correctional Facility Employee ☐ Migrant/Seasonal Worker ☐ None (of the above) ☐ Unknown

Patient's current occupation(s)

Patient's current industry(s)

Patient Lived outside U.S. for > 2 months?

○ Yes ○ No ○ Unknown

If Yes, enter country (1)

If Yes, enter country (2)

If Yes, enter country (3)

Other Risk Factors

Risk Factor	Indicator
Diabetic at Diagnostic Evaluation	
Homeless in the Past 12 Months	
Homeless Ever	
Resident of Correctional Facility at Diagnostic Evaluation. If yes, select facility	
Resident of Correctional Facility Ever	
Resident of Long-Term Care Facility at Diagnostic Evaluation. If yes, select facility	
Injecting Drug Use in the Past 12 Months	
Noninjecting Drug Use in the Past 12 Months	
Heavy Alcohol Use in the Past 12 Months	
TFT-α Antagonist Therapy	
Post-Organ Transplantation	
End Stage Renal Disease	
Viral Hepatitis (B or C only)	
Other Immunocompromise (other than HIV/AIDS)	
Other (Specify:)	

Current Smoking Status at Diagnostic Evaluation

Risk Factors

Occupation and Industry

Has the patient ever worked as one of the following? *(select all that apply)*

☐ Health Care Worker ☐ Correctional Facility Employee ☐ Migrant/Seasonal Worker ☑ None (of the above) ☐ Unknown

Patient's current occupation(s)

Epemiologist

Patient's current industry(s)

State Government

Patient Lived outside U.S. for > 2 months?

◉ Yes ○ No ○ Unknown

If Yes, enter country (1): NICARAGUA

If Yes, enter country (2): COLOMBIA

If Yes, enter country (3):

Other Risk Factors

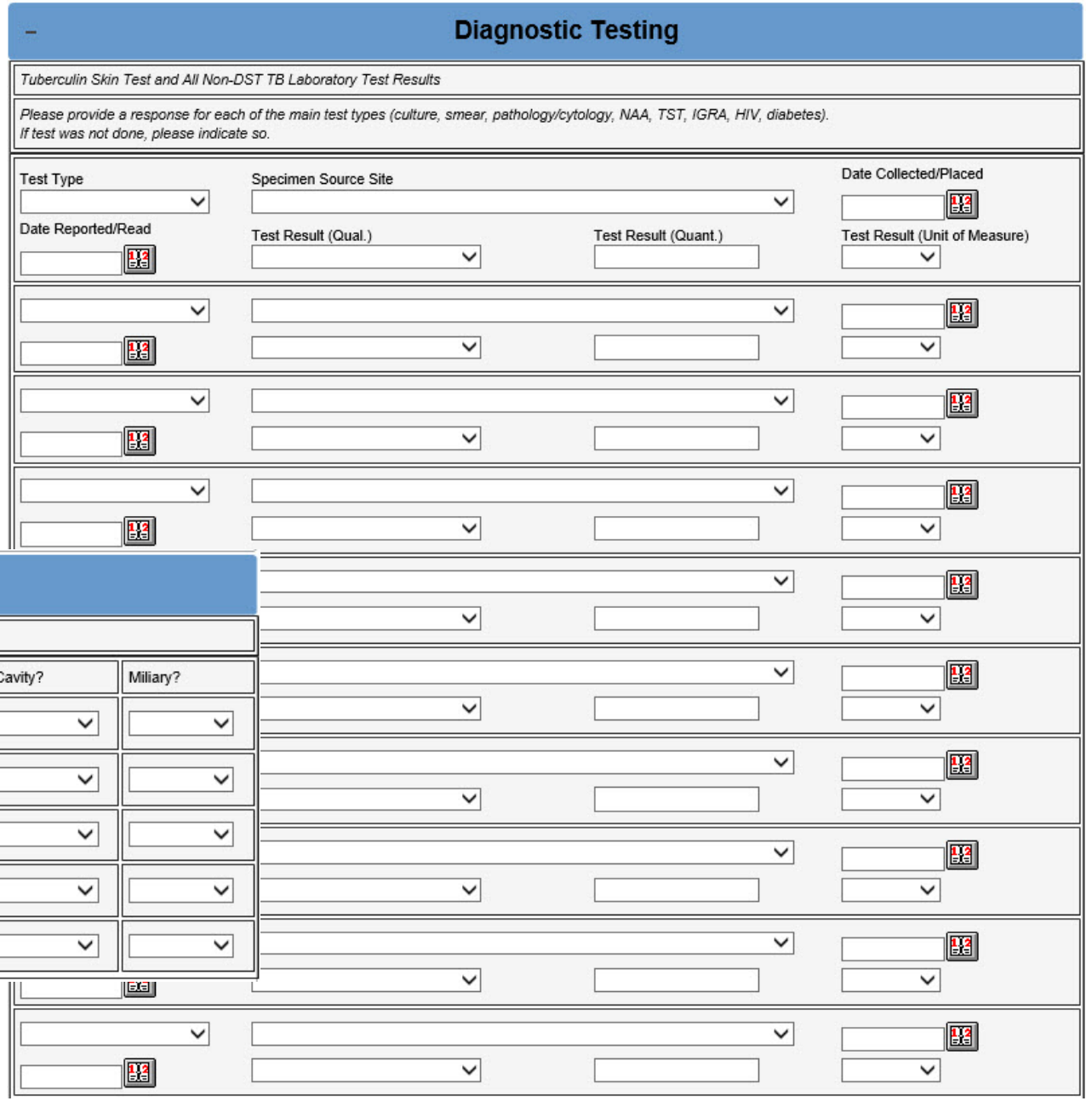
Risk Factor	Indicator
Diabetic at Diagnostic Evaluation	No
Homeless in the Past 12 Months	No
Homeless Ever	No
Resident of Correctional Facility at Diagnostic Evaluation. If yes, select facility	No
Resident of Correctional Facility Ever	No
Resident of Long-Term Care Facility at Diagnostic Evaluation. If yes, select facility	No
Injecting Drug Use in the Past 12 Months	No
Noninjecting Drug Use in the Past 12 Months	No
Heavy Alcohol Use in the Past 12 Months	No
TFT-α Antagonist Therapy	No
Post-Organ Transplantation	No
End Stage Renal Disease	No
Viral Hepatitis (B or C only)	No
Other Immunocompromise (other than HIV/AIDS)	No
Other (Specify:)	No

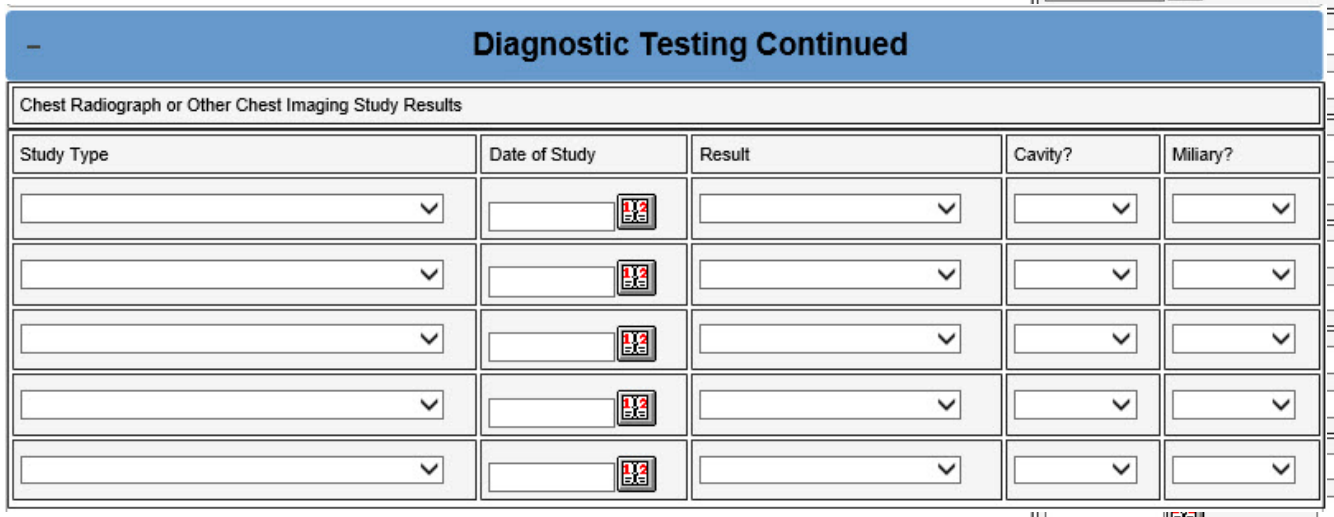
Current Smoking Status at Diagnostic Evaluation: Never smoker

DIAGNOSTIC TESTING

Tuberculin Skin Test and All Non-DST TB Laboratory Test Results

Chest Radiograph and Other Imaging Study Result





DIAGNOSTIC TESTING

Tuberculin Skin Test and All Non-DST TB Laboratory Test Results

Chest Radiograph and Other Imaging Study Result

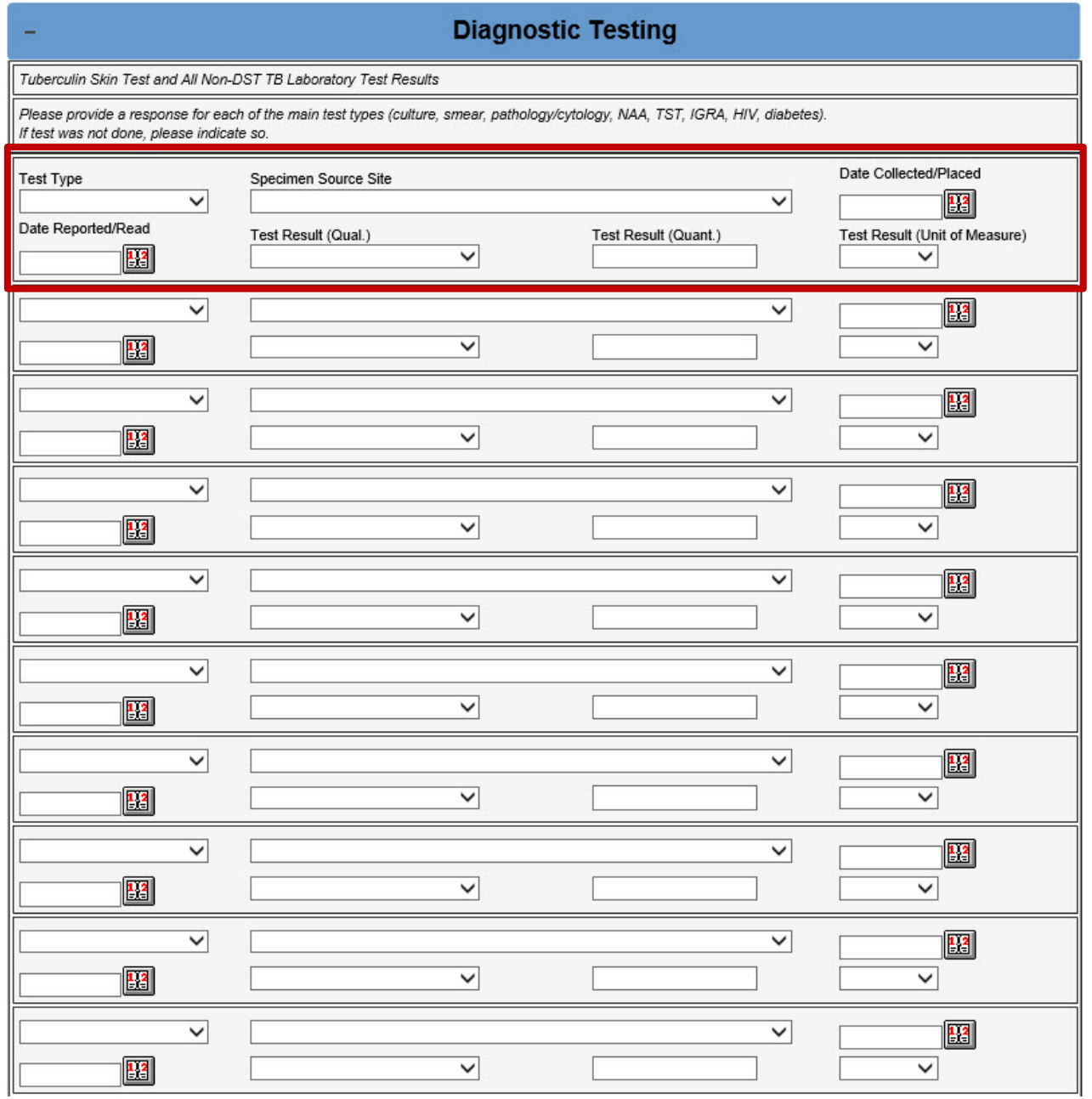
Always specify test results/status for at least initial TST, initial IGRA, initial sputum smear, initial sputum culture, initial NAA, and initial HIV test.

If diabetic also report a Hemoglobin A1c.
If HIV positive also report CD4 count.

Also include the initial result of smear and culture performed on a specimen other than sputum.

Purpose: To verify that the case meets the surveillance definition for TB and to identify laboratory test characteristics of TB cases.

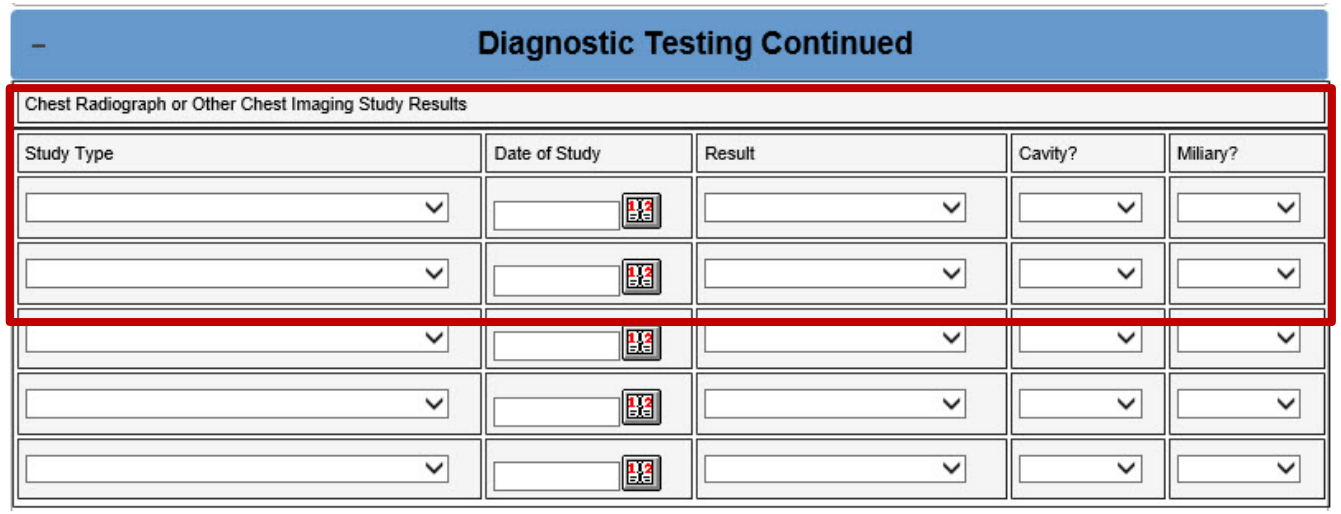
2020 RVCT Reference Manual pg. 38-41



DIAGNOSTIC TESTING

Tuberculin Skin Test and All Non-DST TB Laboratory Test Results

Chest Radiograph and Other Imaging Study Result



Always specify study type and result/status for at least Initial plain **chest** x-ray and initial **chest** CT scan. Enter "Not Done" as applicable. Multiple results may be entered.

Also include the initial result of any other chest imaging studies performed (i.e. MRI or PET)

Purpose: To verify that the case meets the surveillance definition for TB and to identify imaging test characteristics of TB cases.

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Diagnostic Testing

Tuberculin Skin Test and All Non-DST TB Laboratory Test Results

Please provide a response for each of the main test types (culture, smear, pathology/cytology, NAA, TST, IGRA, HIV, diabetes).
If test was not done, please indicate so.

Test Type	Specimen Source Site	Test Result (Qual.)	Test Result (Quant.)	Test Result (Unit of Measure)	Date Collected/Placed	Date Reported/Read
HIV Status	Blood	Negative			06/01/2020	06/02/2020
Tuberculin Skin Test		Not Done				
IGRA-QFT	Blood	Positive			06/01/2020	06/03/2020
Smear	Sputum	Negative			06/01/2020	06/02/2020
NAA	Sputum	Negative			06/01/2020	06/03/2020
Culture	Sputum				06/01/2020	06/25/2020

– Diagnostic Testing Continued

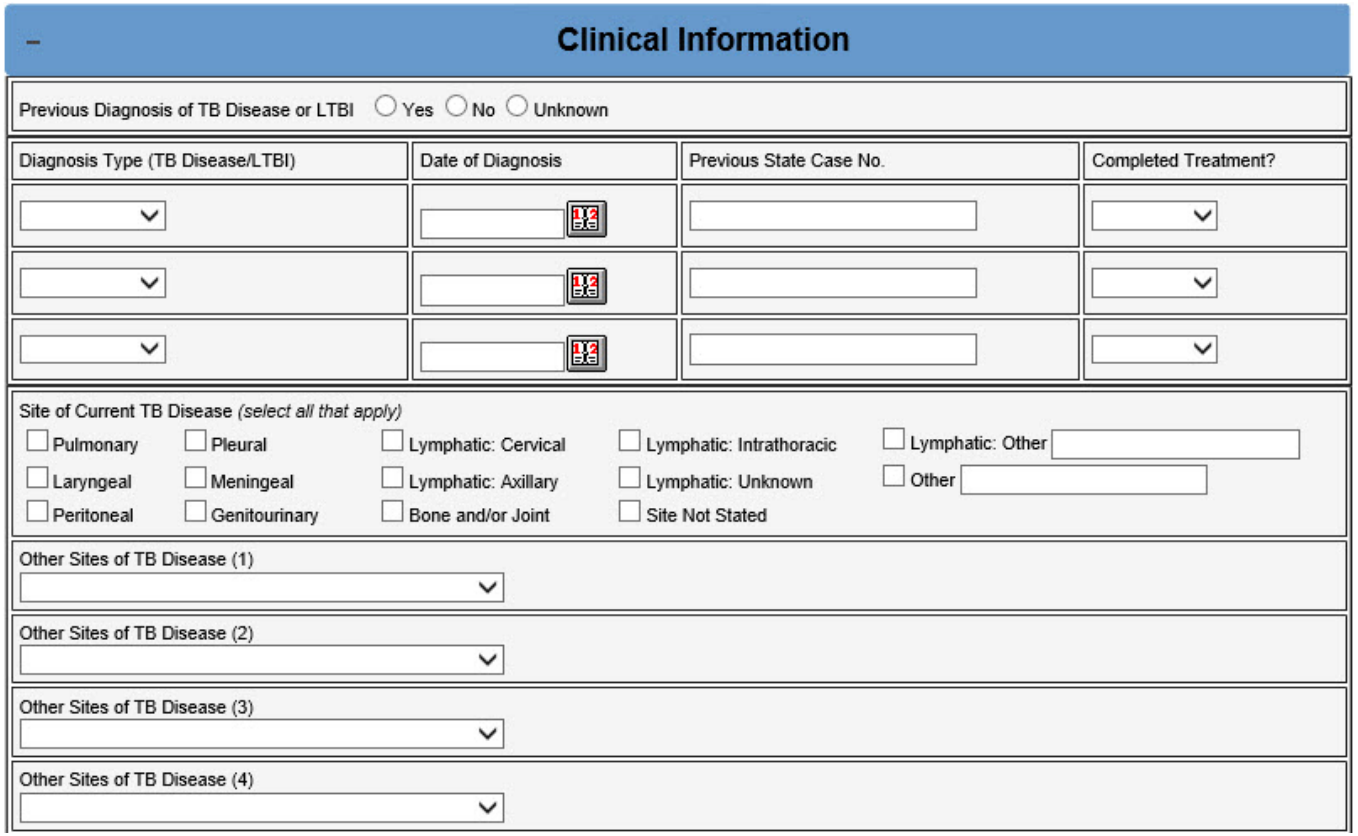
Chest Radiograph or Other Chest Imaging Study Results

Study Type	Date of Study	Result	Cavity?	Miliary?
Plain chest X-ray (procedure)	06/01/2020	Consistent with TB	No	No
Computed tomography of chest (procedure)		Not done (qualifier value)		

CLINICAL HISTORY & FINDINGS

Has the Patient been Previously Diagnosed with TB Disease or LTBI?

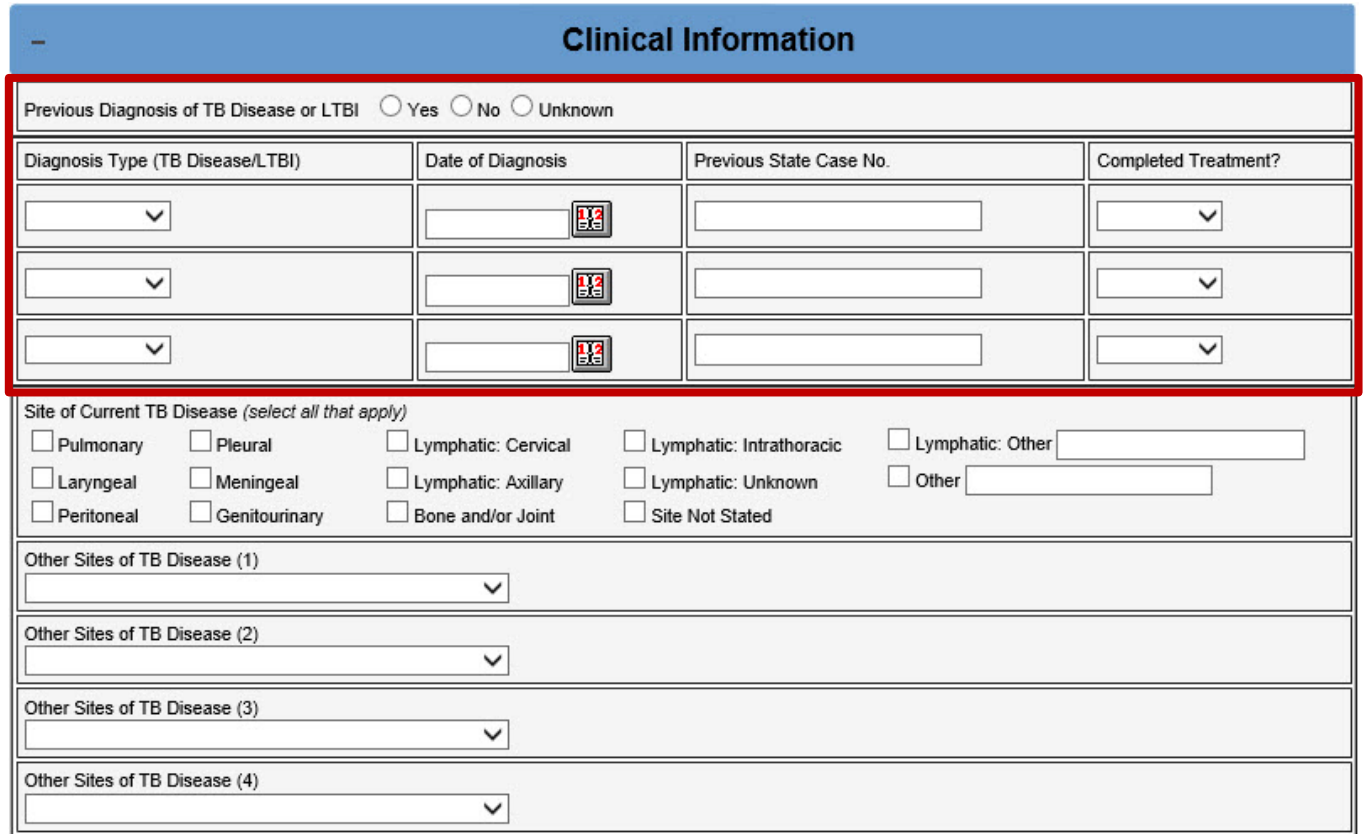
Site of TB Disease



CLINICAL HISTORY & FINDINGS

Has the Patient been Previously Diagnosed with TB Disease or LTBI?

Site of TB Disease



Specify whether the patient had a previous diagnosis of either TB disease or LTBI. If yes, specify whether TB or LTBI, approximate date of diagnosis, previous state case number (if TB), and whether they completed a full course of appropriate treatment.

Purpose: To determine whether the patient has a prior history of TB disease or LTBI

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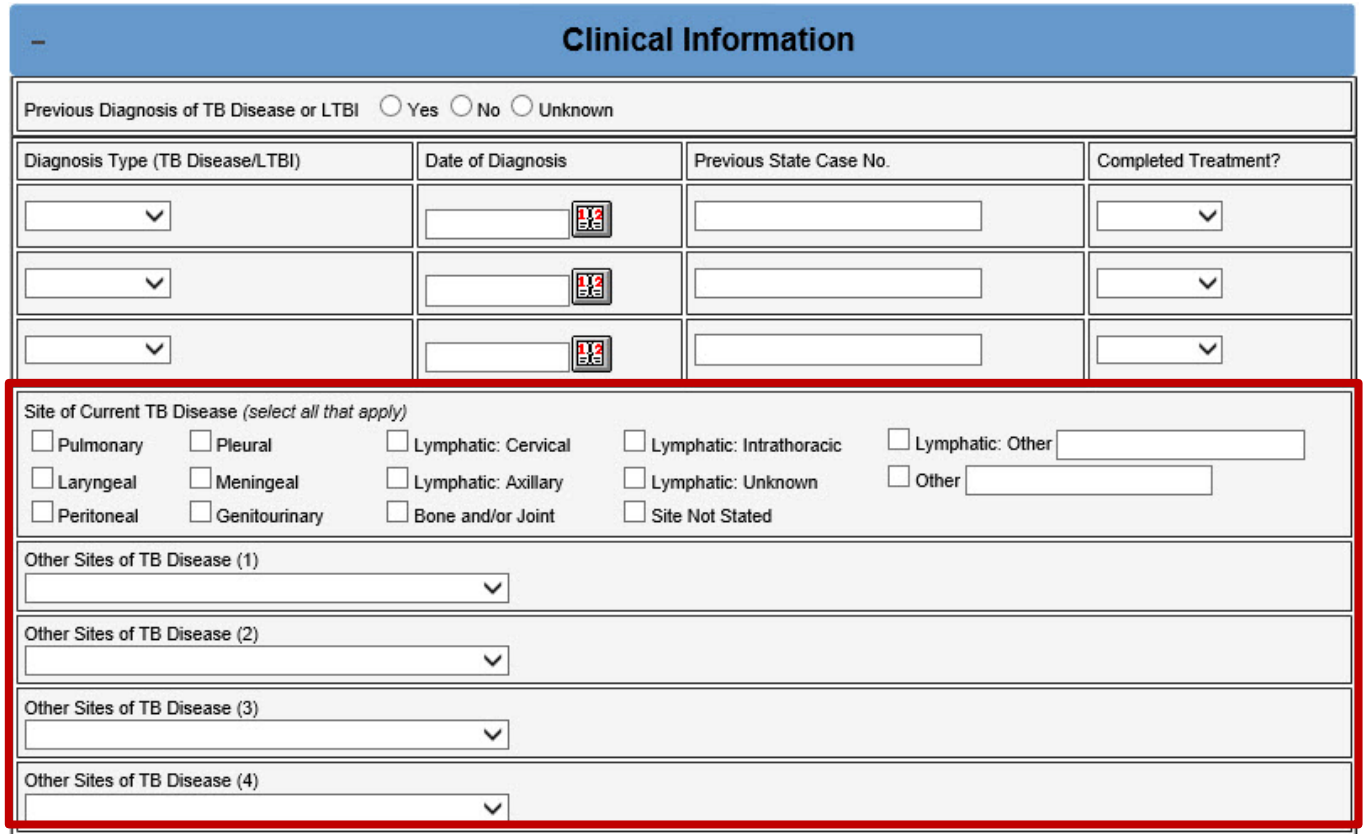
CLINICAL HISTORY & FINDINGS

Has the Patient been Previously Diagnosed with TB Disease or LTBI?

Site of TB Disease



Select all anatomic sites where TB disease was identified in the patient by checking the relevant box. If there is not a corresponding check box, record the site in "other" and select it from the "other sites of TB disease" drop down.

If there is evidence of more than one organ or disease site involved, select all involved sites.

Purpose: To document site of TB disease

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Clinical Information

Previous Diagnosis of TB Disease or LTBI ○ Yes ◉ No ○ Unknown

Diagnosis Type (TB Disease/LTBI)	Date of Diagnosis	Previous State Case No.	Completed Treatment?

Site of Current TB Disease *(select all that apply)*

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

Other Sites of TB Disease (1)

Other Sites of TB Disease (2)

Other Sites of TB Disease (3)

Other Sites of TB Disease (4)

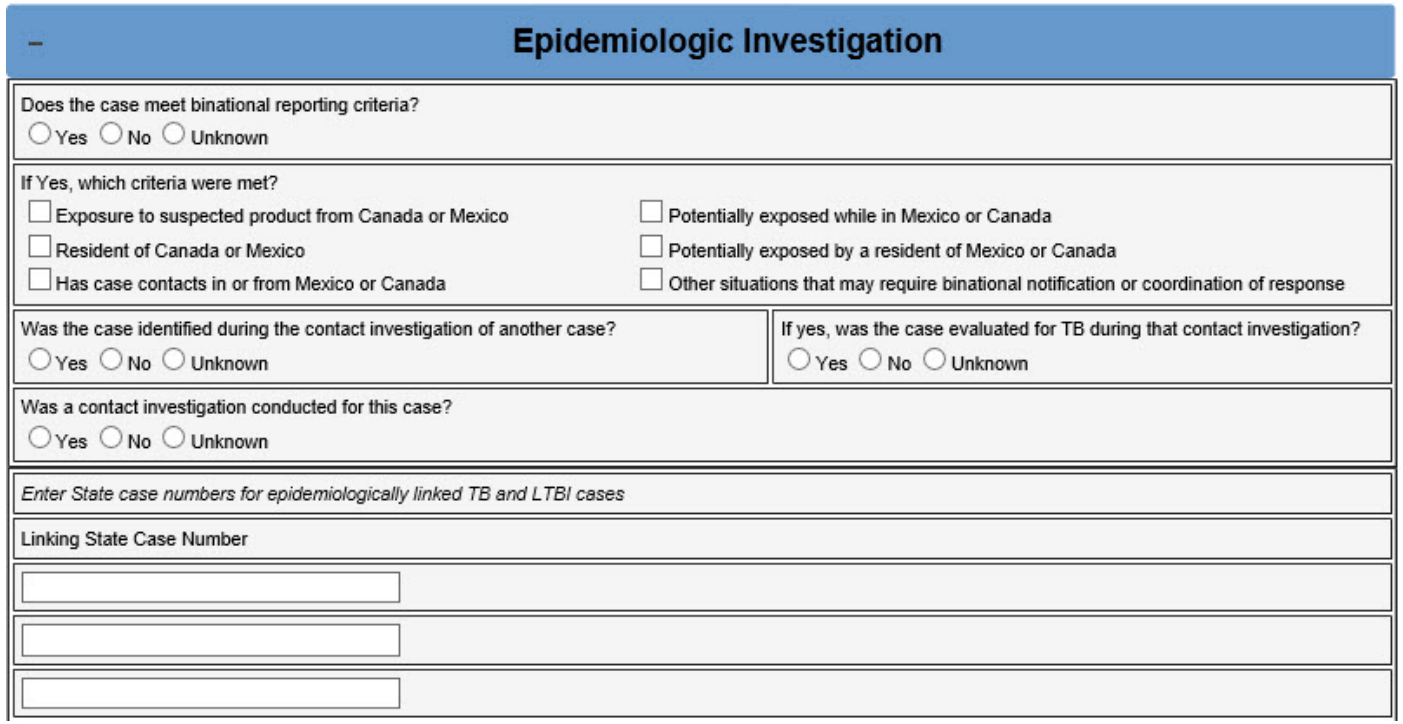
EPIDEMIOLOGIC INVESTIGATION

Case Meets Binational Reporting Criteria?

Case Identified During a Contact Investigation of Another Case?

Contact Investigation Conducted for This Case?

Table of Known TB and LTBI Cases Epidemiologically Linked to This Case



Epidemiologic Investigation

Does the case meet binational reporting criteria?
○ Yes ○ No ○ Unknown

If Yes, which criteria were met?
☐ Exposure to suspected product from Canada or Mexico
☐ Resident of Canada or Mexico
☐ Has case contacts in or from Mexico or Canada
☐ Potentially exposed while in Mexico or Canada
☐ Potentially exposed by a resident of Mexico or Canada
☐ Other situations that may require binational notification or coordination of response

Was the case identified during the contact investigation of another case?
○ Yes ○ No ○ Unknown

If yes, was the case evaluated for TB during that contact investigation?
○ Yes ○ No ○ Unknown

Was a contact investigation conducted for this case?
○ Yes ○ No ○ Unknown

Enter State case numbers for epidemiologically linked TB and LTBI cases

Linking State Case Number

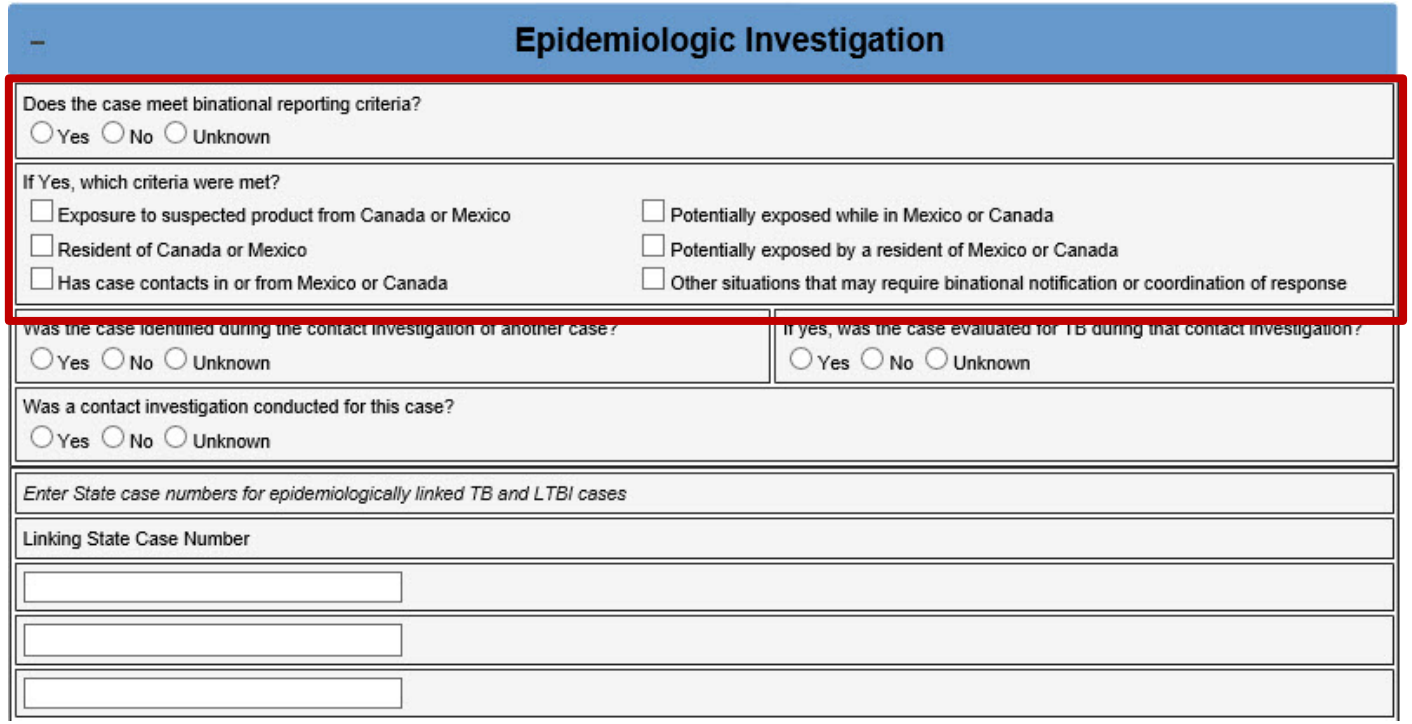
EPIDEMIOLOGIC INVESTIGATION

Case Meets Binational Reporting Criteria?

Case Identified During a Contact Investigation of Another Case?

Contact Investigation Conducted for This Case?

Table of Known TB and LTBI Cases Epidemiologically Linked to This Case



Indicate whether the case meets one of the criteria listed below to be classified as a binational case.

If yes, select all criteria that were met.

Purpose: To determine whether the case meets binational reporting criteria

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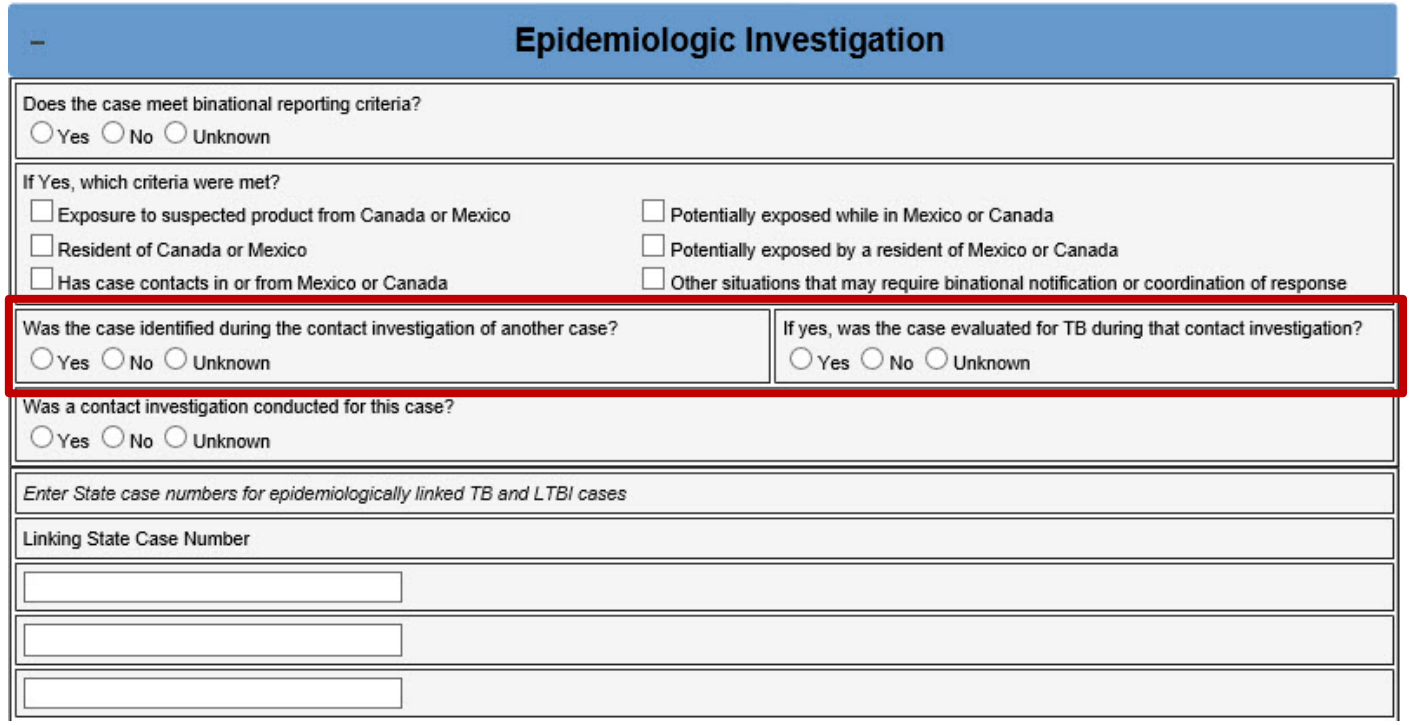
EPIDEMIOLOGIC INVESTIGATION

Case Meets Binational Reporting Criteria?

Case Identified During a Contact Investigation of Another Case?

Contact Investigation Conducted for This Case?

Table of Known TB and LTBI Cases Epidemiologically Linked to This Case



Epidemiologic Investigation

Does the case meet binational reporting criteria?
Yes No Unknown

If Yes, which criteria were met?
- Exposure to suspected product from Canada or Mexico
- Resident of Canada or Mexico
- Has case contacts in or from Mexico or Canada
- Potentially exposed while in Mexico or Canada
- Potentially exposed by a resident of Mexico or Canada
- Other situations that may require binational notification or coordination of response

Was the case identified during the contact investigation of another case?
Yes No Unknown

If yes, was the case evaluated for TB during that contact investigation?
Yes No Unknown

Was a contact investigation conducted for this case?
Yes No Unknown

Enter State case numbers for epidemiologically linked TB and LTBI cases

Linking State Case Number

Indicate whether the case had been identified during another case's contact investigation. If yes, indicate whether the patient was evaluated for TB disease during that investigation.

Purpose: To determine whether the case was identified during the contact investigation of another TB case.

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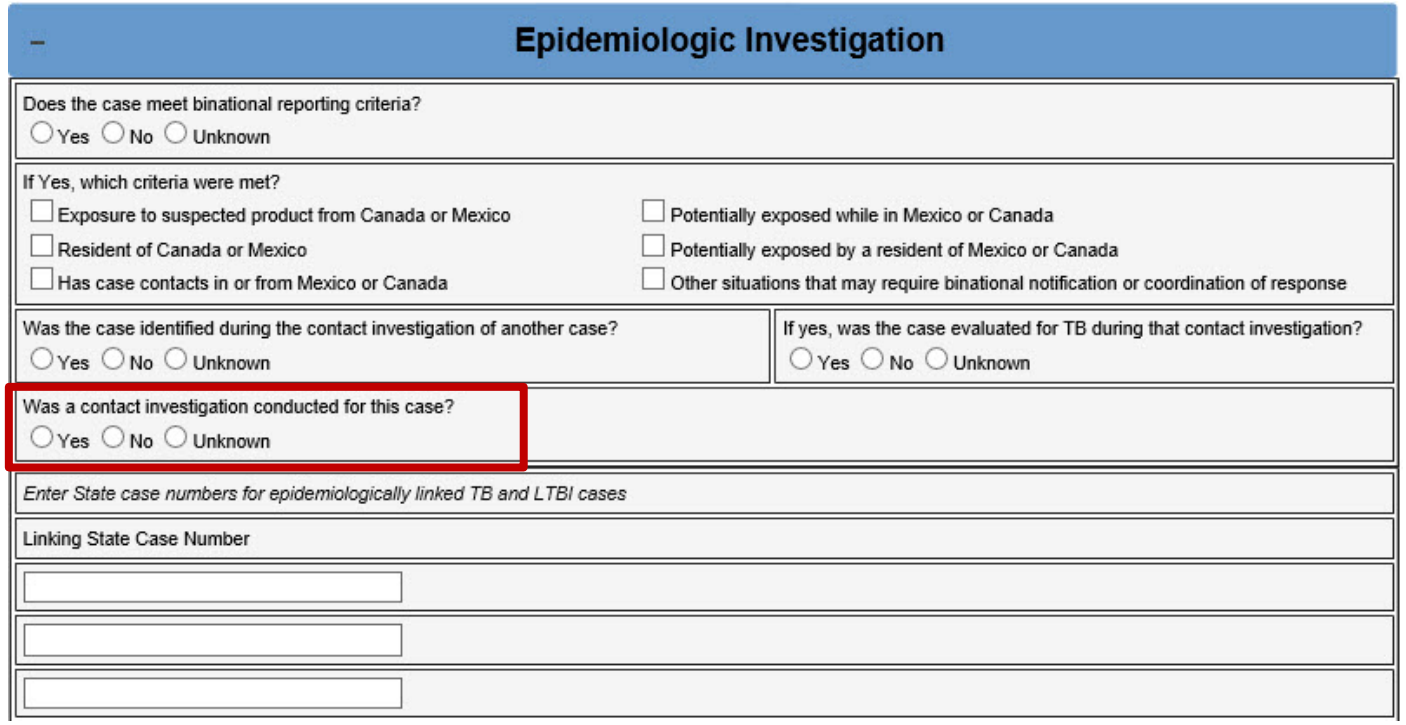
EPIDEMIOLOGIC INVESTIGATION

Case Meets Binational Reporting Criteria?

Case Identified During a Contact Investigation of Another Case?

Contact Investigation Conducted for This Case?

Table of Known TB and LTBI Cases Epidemiologically Linked to This Case



Indicate whether there a contact investigation was initiated for this case.

Note: The question should be answered “yes” if a CI was conducted that adequately identified contacts related to this case, even if the investigation was prompted by identification of a different case.

Purpose: To determine if a contact investigation was performed around **this** case.

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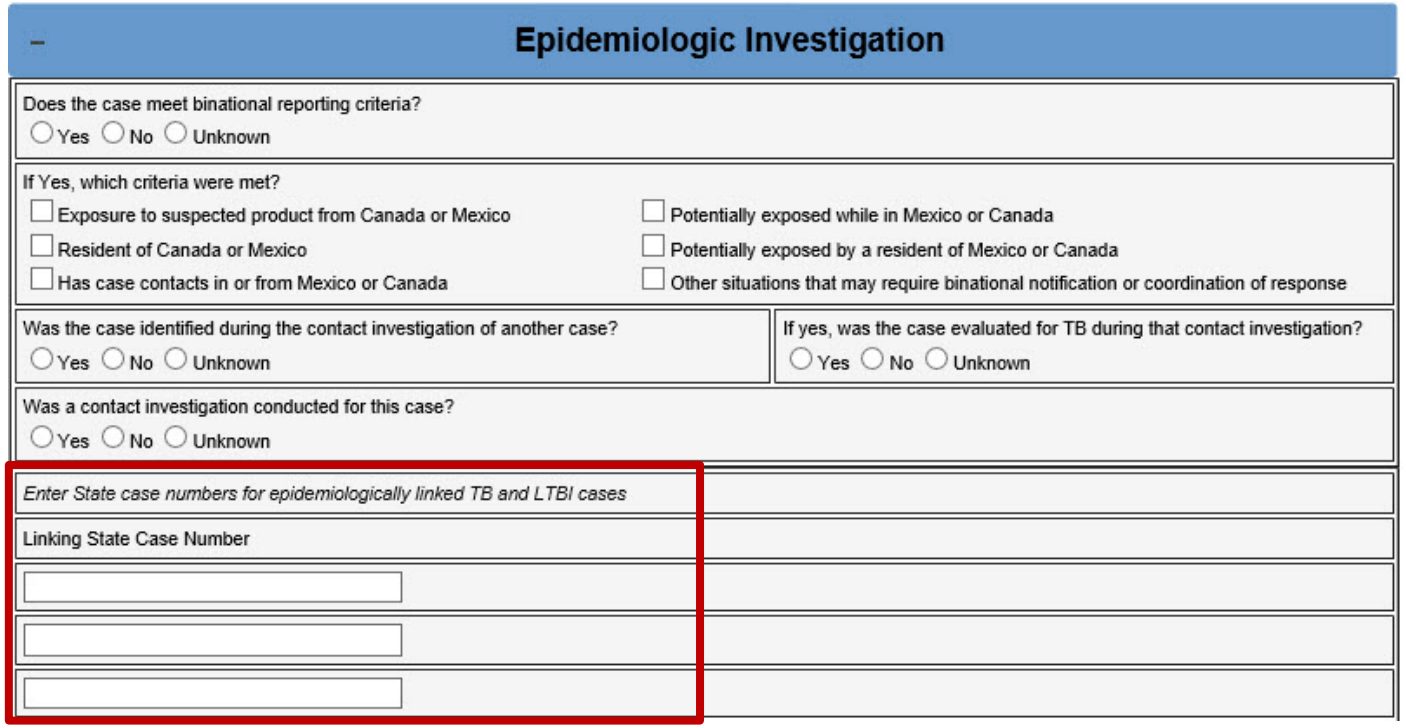
EPIDEMIOLOGIC INVESTIGATION

Case Meets Binational Reporting Criteria?

Case Identified During a Contact Investigation of Another Case?

Contact Investigation Conducted for This Case?

Table of Known TB and LTBI Cases Epidemiologically Linked to This Case



Epidemiologic Investigation

Does the case meet binational reporting criteria?
Yes No Unknown

If Yes, which criteria were met?
- Exposure to suspected product from Canada or Mexico
- Resident of Canada or Mexico
- Has case contacts in or from Mexico or Canada
- Potentially exposed while in Mexico or Canada
- Potentially exposed by a resident of Mexico or Canada
- Other situations that may require binational notification or coordination of response

Was the case identified during the contact investigation of another case?
Yes No Unknown

If yes, was the case evaluated for TB during that contact investigation?
Yes No Unknown

Was a contact investigation conducted for this case?
Yes No Unknown

Enter State case numbers for epidemiologically linked TB and LTBI cases

Linking State Case Number

Specify state case number (ex: 2020MI000000000) for all cases epidemiologically linked to this case.

This will usually be entered by the MDHHS TB Unit

Purpose: To determine potential transmission links between cases.

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Epidemiologic Investigation

Does the case meet binational reporting criteria?

○ Yes ◉ No ○ Unknown

If Yes, which criteria were met?

- ☐ Exposure to suspected product from Canada or Mexico
- ☐ Resident of Canada or Mexico
- ☐ Has case contacts in or from Mexico or Canada
- ☐ Potentially exposed while in Mexico or Canada
- ☐ Potentially exposed by a resident of Mexico or Canada
- ☐ Other situations that may require binational notification or coordination of response

Was the case identified during the contact investigation of another case?

○ Yes ◉ No ○ Unknown

If yes, was the case evaluated for TB during that contact investigation?

○ Yes ○ No ○ Unknown

Was a contact investigation conducted for this case?

◉ Yes ○ No ○ Unknown

Enter State case numbers for epidemiologically linked TB and LTBI cases

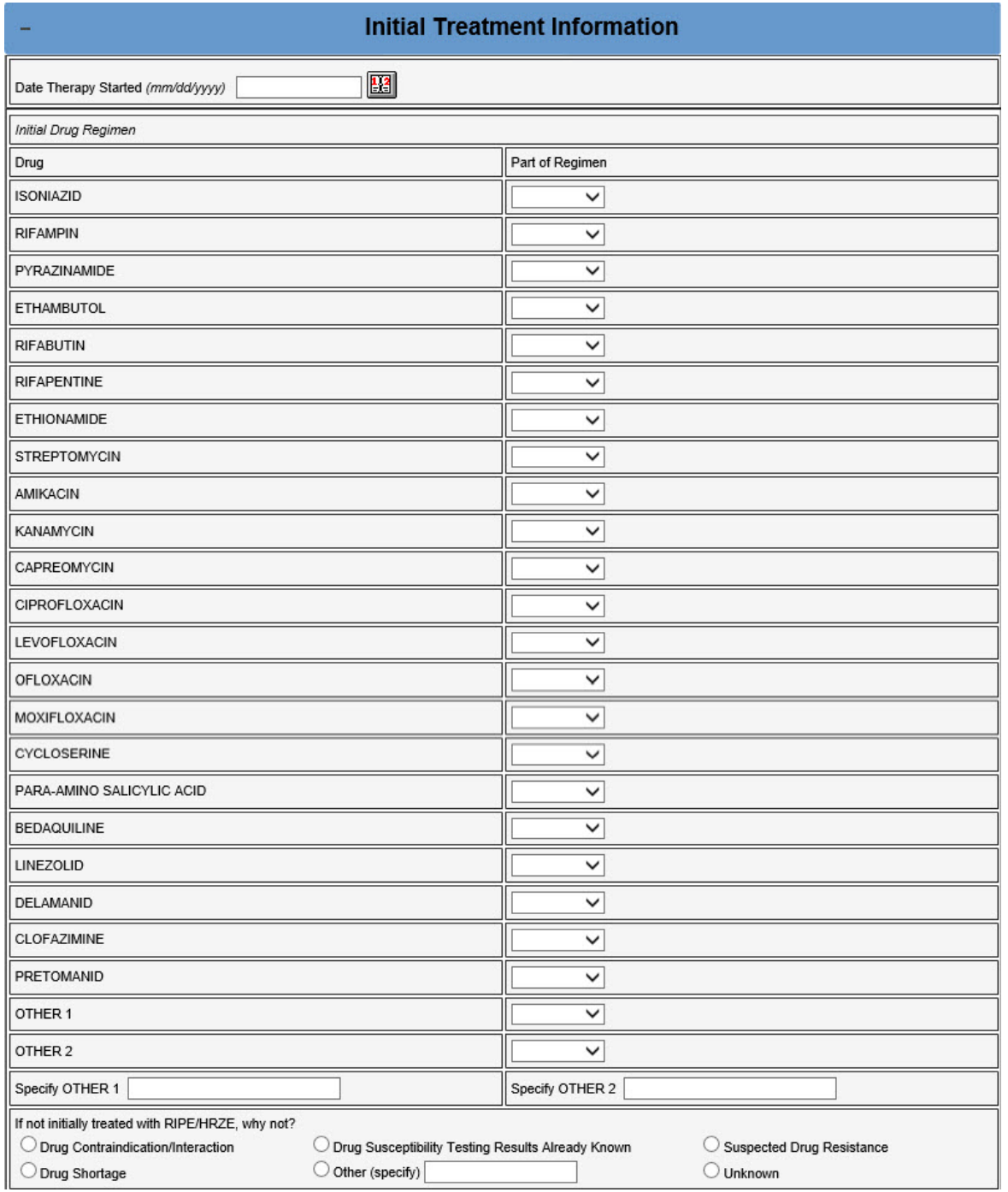
Linking State Case Number

INITIAL TREATMENT INFORMATION

Date Therapy Started

Initial Drug Regimen

If Initial Drug Regimen Not RIPE/HRZE, Why Not?



Initial Treatment Information

Date Therapy Started *(mm/dd/yyyy)*

Initial Drug Regimen

Drug	Part of Regimen
ISONIAZID	
RIFAMPIN	
PYRAZINAMIDE	
ETHAMBUTOL	
RIFABUTIN	
RIFAPENTINE	
ETHIONAMIDE	
STREPTOMYCIN	
AMIKACIN	
KANAMYCIN	
CAPREOMYCIN	
CIPROFLOXACIN	
LEVOFLOXACIN	
OFLOXACIN	
MOXIFLOXACIN	
CYCLOSERINE	
PARA-AMINO SALICYLIC ACID	
BEDAQUILINE	
LINEZOLID	
DELAMANID	
CLOFAZIMINE	
PRETOMANID	
OTHER 1	
OTHER 2	
Specify OTHER 1	Specify OTHER 2

If not initially treated with RIPE/HRZE, why not?

- Drug Contraindication/Interaction
- Drug Susceptibility Testing Results Already Known
- Suspected Drug Resistance
- Drug Shortage
- Other (specify)
- Unknown

INITIAL TREATMENT INFORMATION

Date Therapy Started

Initial Drug Regimen

If Initial Drug Regimen Not RIPE/HRZE, Why Not?

Date the patient began multidrug therapy for confirmed or possible TB disease.

Preferred: Date the patient first ingested medication if documented in a medical record or DOT
Next Alternative: Date medication was first dispensed to the patient as documented by medical or pharmacy record
Last Alternative: Date medication was first prescribed to the patient by the health care provider as documented by a medical or pharmacy record

Purpose: To calculate program management indicators

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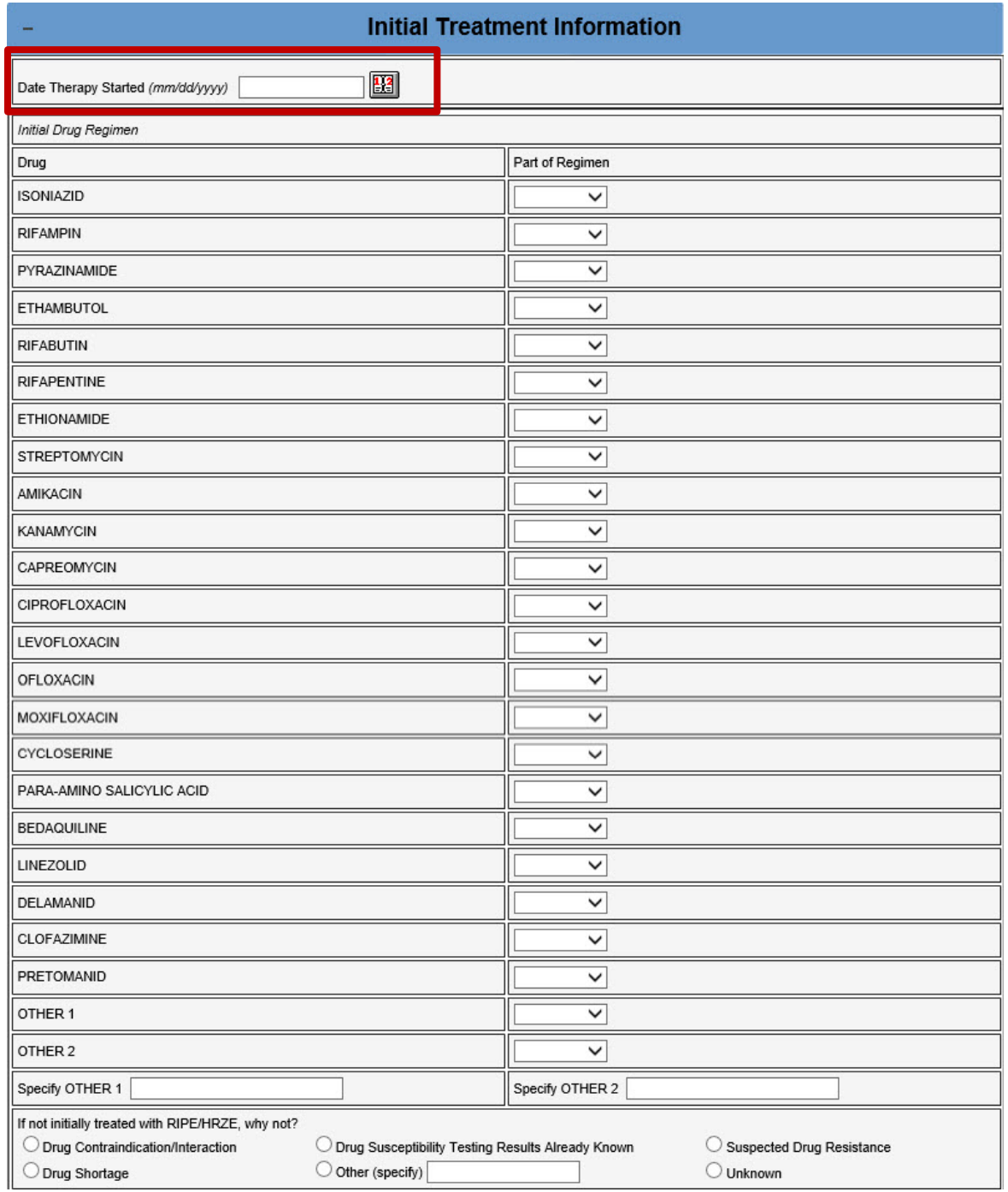

Initial Treatment Information

Date Therapy Started *(mm/dd/yyyy)*

Initial Drug Regimen

Drug	Part of Regimen
ISONIAZID	
RIFAMPIN	
PYRAZINAMIDE	
ETHAMBUTOL	
RIFABUTIN	
RIFAPENTINE	
ETHIONAMIDE	
STREPTOMYCIN	
AMIKACIN	
KANAMYCIN	
CAPREOMYCIN	
CIPROFLOXACIN	
LEVOFLOXACIN	
OFLOXACIN	
MOXIFLOXACIN	
CYCLOSERINE	
PARA-AMINO SALICYLIC ACID	
BEDAQUILINE	
LINEZOLID	
DELAMANID	
CLOFAZIMINE	
PRETOMANID	
OTHER 1	
OTHER 2	
Specify OTHER 1	Specify OTHER 2

If not initially treated with RIPE/HRZE, why not?

Drug Contraindication/Interaction | Drug Susceptibility Testing Results Already Known | Suspected Drug Resistance
Drug Shortage | Other (specify) | Unknown

INITIAL TREATMENT INFORMATION

Date Therapy Started

Initial Drug Regimen

If Initial Drug Regimen Not RIPE/HRZE, Why Not?

For each drug named, indicate whether it was used/prescribed in the initial regimen for treatment of TB disease.

Purpose: To calculate program management indicators

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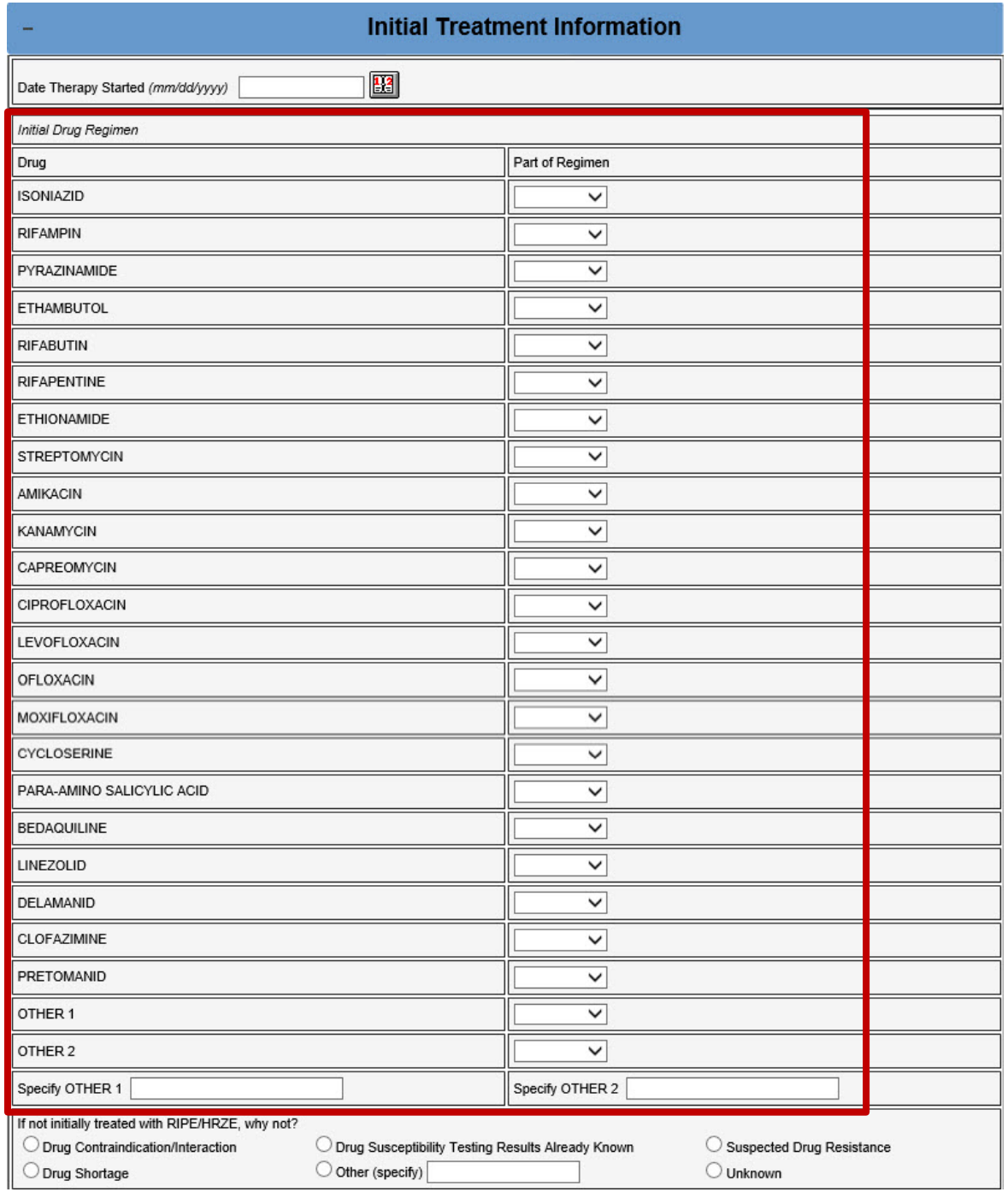

Initial Treatment Information

Date Therapy Started *(mm/dd/yyyy)*

Initial Drug Regimen

Drug	Part of Regimen
ISONIAZID	
RIFAMPIN	
PYRAZINAMIDE	
ETHAMBUTOL	
RIFABUTIN	
RIFAPENTINE	
ETHIONAMIDE	
STREPTOMYCIN	
AMIKACIN	
KANAMYCIN	
CAPREOMYCIN	
CIPROFLOXACIN	
LEVOFLOXACIN	
OFLOXACIN	
MOXIFLOXACIN	
CYCLOSERINE	
PARA-AMINO SALICYLIC ACID	
BEDAQUILINE	
LINEZOLID	
DELAMANID	
CLOFAZIMINE	
PRETOMANID	
OTHER 1	
OTHER 2	
Specify OTHER 1	Specify OTHER 2

If not initially treated with RIPE/HRZE, why not?

Drug Contraindication/Interaction | Drug Susceptibility Testing Results Already Known | Suspected Drug Resistance

Drug Shortage | Other (specify) | Unknown

INITIAL TREATMENT INFORMATION

Date Therapy Started

Initial Drug Regimen

If Initial Drug Regimen Not RIPE/HRZE, Why Not?

If the initial TB treatment regimen was not Isoniazid, Rifampin, Pyrazinamide, and Ethambutol, indicate the reason why.

Only complete if RIPE was not used.

Ex: DST results already known, contraindication, suspected resistance, shortage

Purpose: To calculate program management indicators

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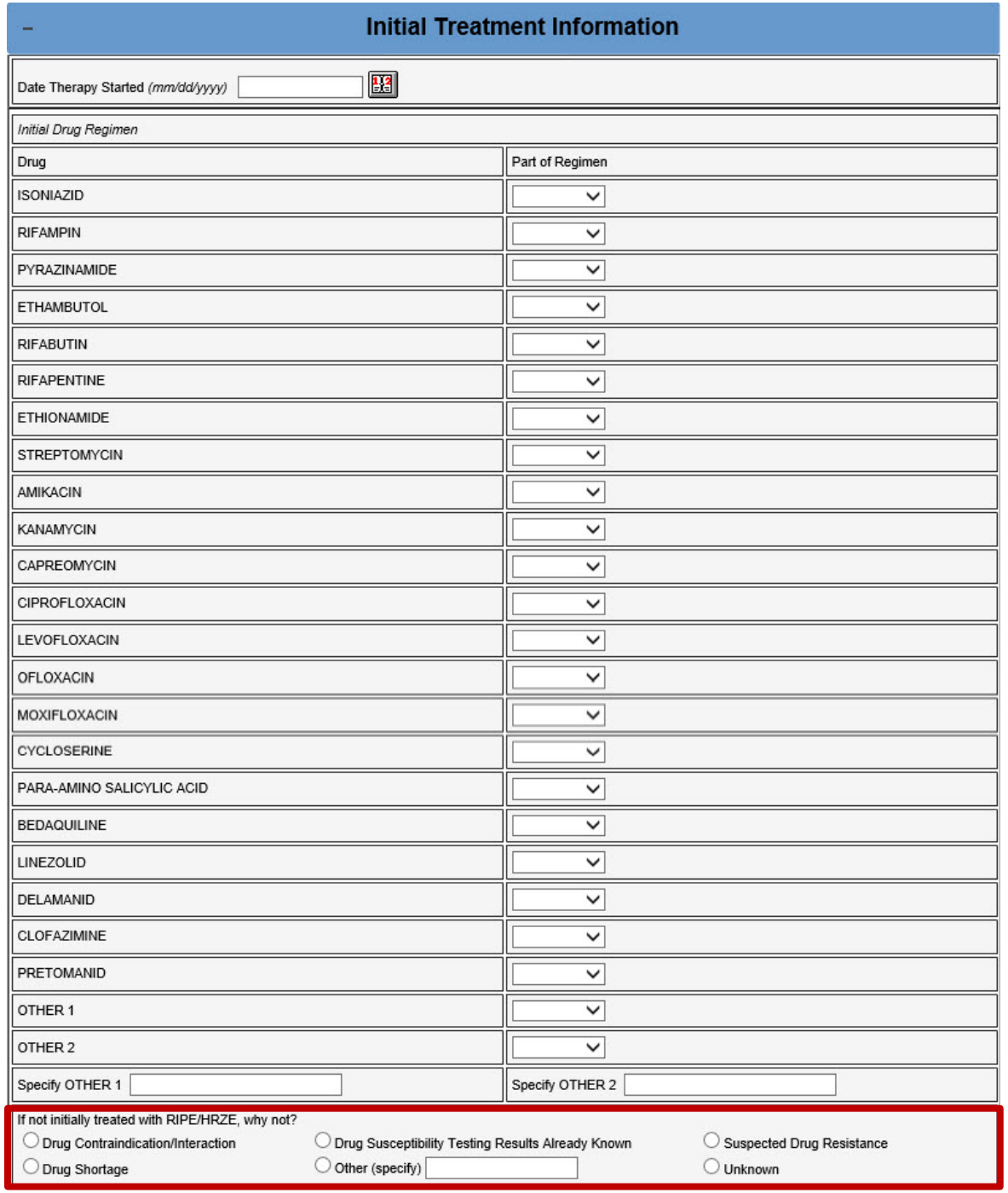


Initial Treatment Information

Date Therapy Started *(mm/dd/yyyy)*

Initial Drug Regimen

Drug	Part of Regimen
ISONIAZID	
RIFAMPIN	
PYRAZINAMIDE	
ETHAMBUTOL	
RIFABUTIN	
RIFAPENTINE	
ETHIONAMIDE	
STREPTOMYCIN	
AMIKACIN	
KANAMYCIN	
CAPREOMYCIN	
CIPROFLOXACIN	
LEVOFLOXACIN	
OFLOXACIN	
MOXIFLOXACIN	
CYCLOSERINE	
PARA-AMINO SALICYLIC ACID	
BEDAQUILINE	
LINEZOLID	
DELAMANID	
CLOFAZIMINE	
PRETOMANID	
OTHER 1	
OTHER 2	
Specify OTHER 1	Specify OTHER 2

If not initially treated with RIPE/HRZE, why not?

- Drug Contraindication/Interaction
- Drug Susceptibility Testing Results Already Known
- Suspected Drug Resistance
- Drug Shortage
- Other (specify)
- Unknown

Initial Treatment Information

Date Therapy Started *(mm/dd/yyyy)* 06/25/2020

Initial Drug Regimen

Drug	Part of Regimen
ISONIAZID	Yes
RIFAMPIN	Yes
PYRAZINAMIDE	Yes
ETHAMBUTOL	Yes
RIFABUTIN	No
RIFAPENTINE	No
ETHIONAMIDE	No
STREPTOMYCIN	No
AMIKACIN	No
KANAMYCIN	No
CAPREOMYCIN	No
CIPROFLOXACIN	No
LEVOFLOXACIN	No
OFLOXACIN	No
MOXIFLOXACIN	No
CYCLOSERINE	No
PARA-AMINO SALICYLIC ACID	No
BEDAQUILINE	No
LINEZOLID	No
DELAMANID	No
CLOFAZIMINE	No
PRETOMANID	No
OTHER 1	No
OTHER 2	No
Specify OTHER 1	Specify OTHER 2

If not initially treated with RIPE/HRZE, why not?

- ○ Drug Contraindication/Interaction
- ○ Drug Susceptibility Testing Results Already Known
- ○ Suspected Drug Resistance
- ○ Drug Shortage
- ○ Other (specify)
- ○ Unknown

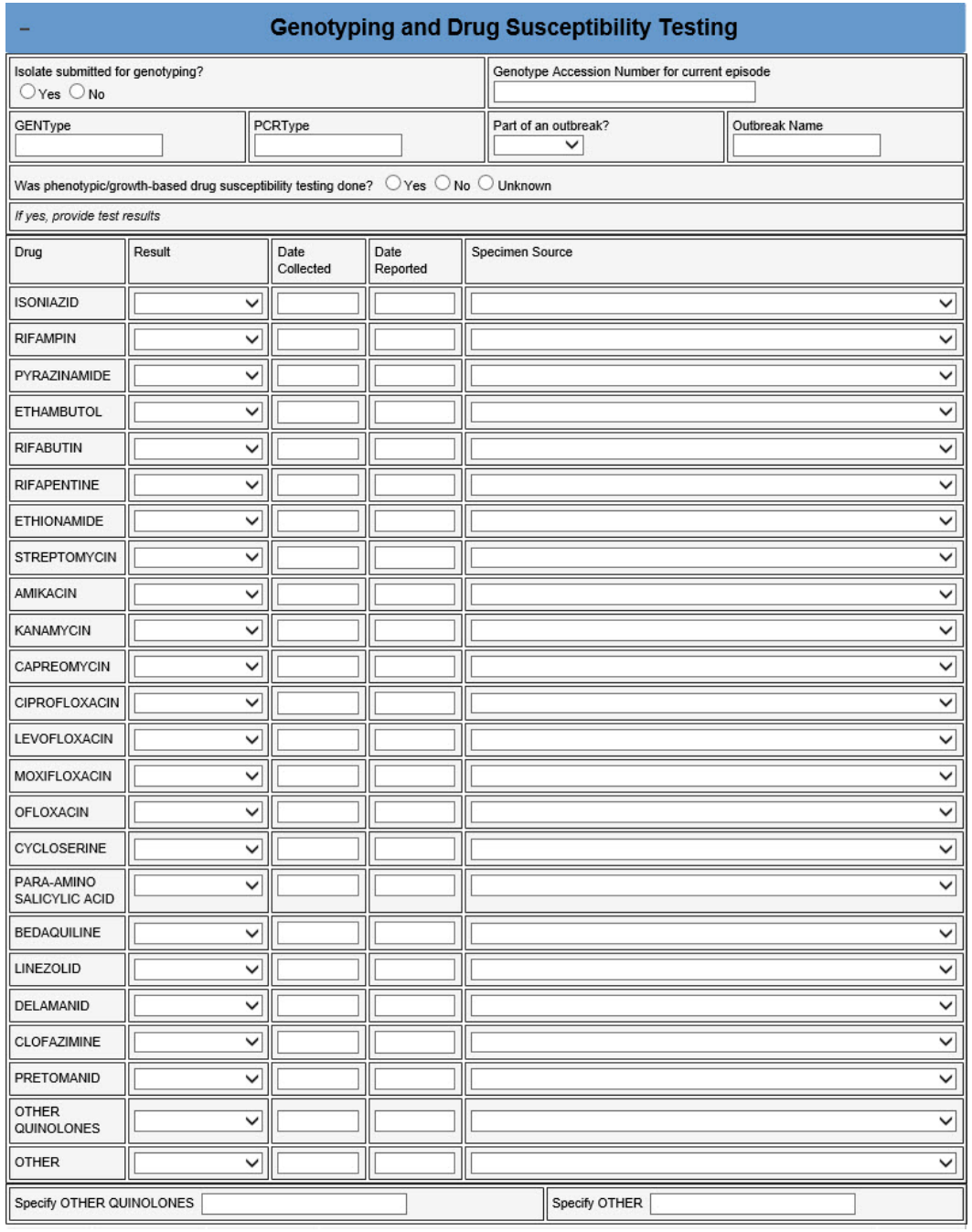
GENOTYPING & DRUG SUSCEPTIBILITY TESTING

Isolate Submitted for Genotyping?

Was Phenotypic/Growth-Based Drug Susceptibility Testing Done?

Was Genotyping/Molecular Drug Susceptibility Done?

Was the Patient Treated as an MDR TB Case (Regardless of DST Results)?



Genotyping and Drug Susceptibility Testing

Isolate submitted for genotyping? ○ Yes ○ No		Genotype Accession Number for current episode	
GENType	PCRType	Part of an outbreak?	Outbreak Name

Was phenotypic/growth-based drug susceptibility testing done? ○ Yes ○ No ○ Unknown

If yes, provide test results

Drug	Result	Date Collected	Date Reported	Specimen Source
ISONIAZID				
RIFAMPIN				
PYRAZINAMIDE				
ETHAMBUTOL				
RIFABUTIN				
RIFAPENTINE				
ETHIONAMIDE				
STREPTOMYCIN				
AMIKACIN				
KANAMYCIN				
CAPREOMYCIN				
CIPROFLOXACIN				
LEVOFLOXACIN				
MOXIFLOXACIN				
OFLOXACIN				
CYCLOSERINE				
PARA-AMINO SALICYLIC ACID				
BEDAQUILINE				
LINEZOLID				
DELAMANID				
CLOFAZIMINE				
PRETOMANID				
OTHER QUINOLONES				
OTHER				

Specify OTHER QUINOLONES	Specify OTHER

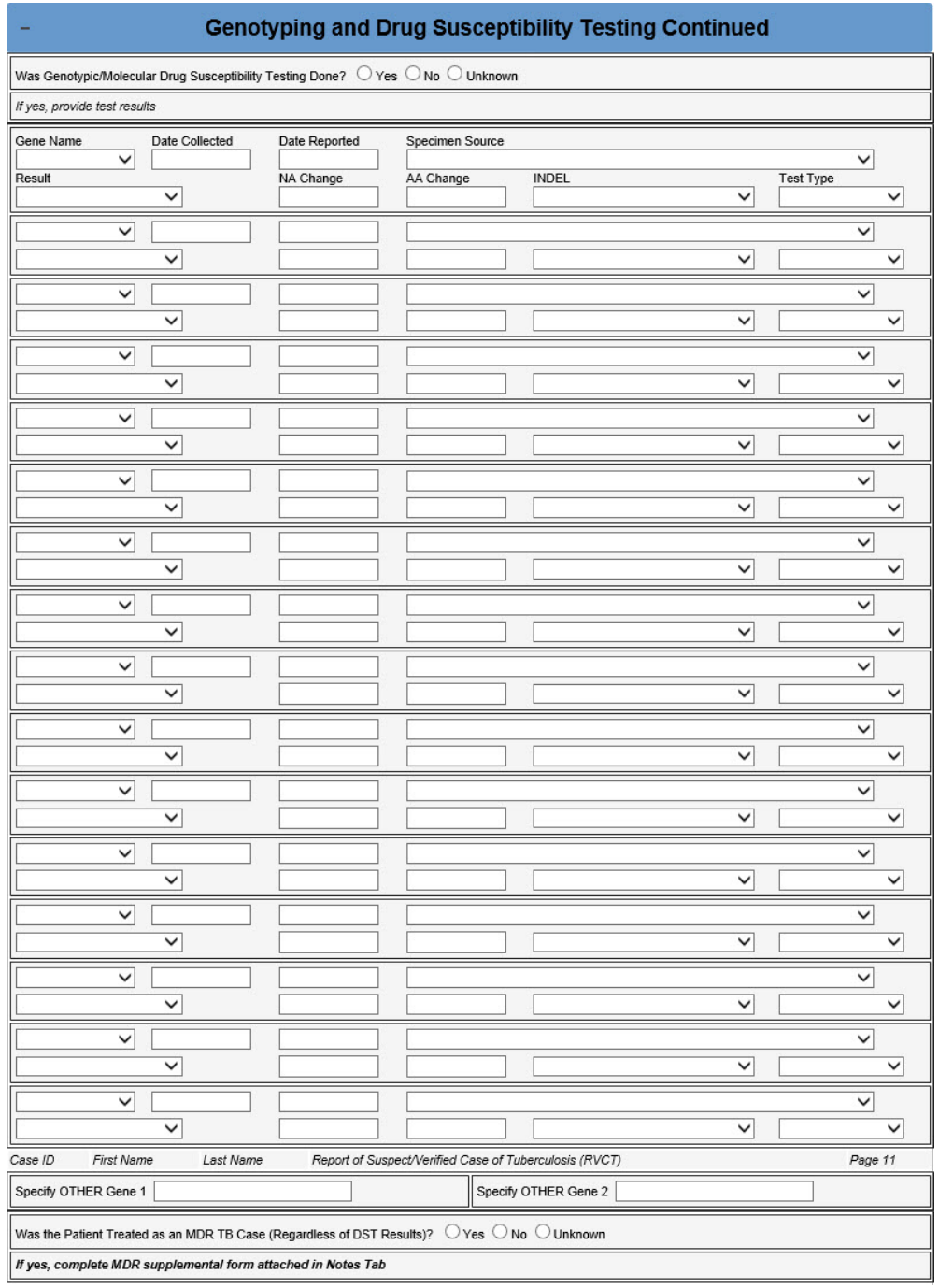
GENOTYPING & DRUG SUSCEPTIBILITY TESTING

Isolate Submitted for Genotyping?

Was Phenotypic/Growth-Based Drug Susceptibility Testing Done?

Was Genotyping/Molecular Drug Susceptibility Done?

Was the Patient Treated as an MDR TB Case (Regardless of DST Results)?



Genotyping and Drug Susceptibility Testing Continued

Was Genotypic/Molecular Drug Susceptibility Testing Done? ○ Yes ○ No ○ Unknown

If yes, provide test results

Gene Name	Date Collected	Date Reported	Specimen Source		
Result		NA Change	AA Change	INDEL	Test Type

Case ID *First Name* *Last Name* *Report of Suspect/Verified Case of Tuberculosis (RVCT)* *Page 11*

Specify OTHER Gene 1 | Specify OTHER Gene 2

Was the Patient Treated as an MDR TB Case (Regardless of DST Results)? ○ Yes ○ No ○ Unknown

If yes, complete MDR supplemental form attached in Notes Tab

GENOTYPING & DRUG SUSCEPTIBILITY TESTING

Isolate Submitted for Genotyping?

Was Phenotypic/Growth-Based Drug Susceptibility Testing Done?

Was Genotyping/Molecular Drug Susceptibility Done?

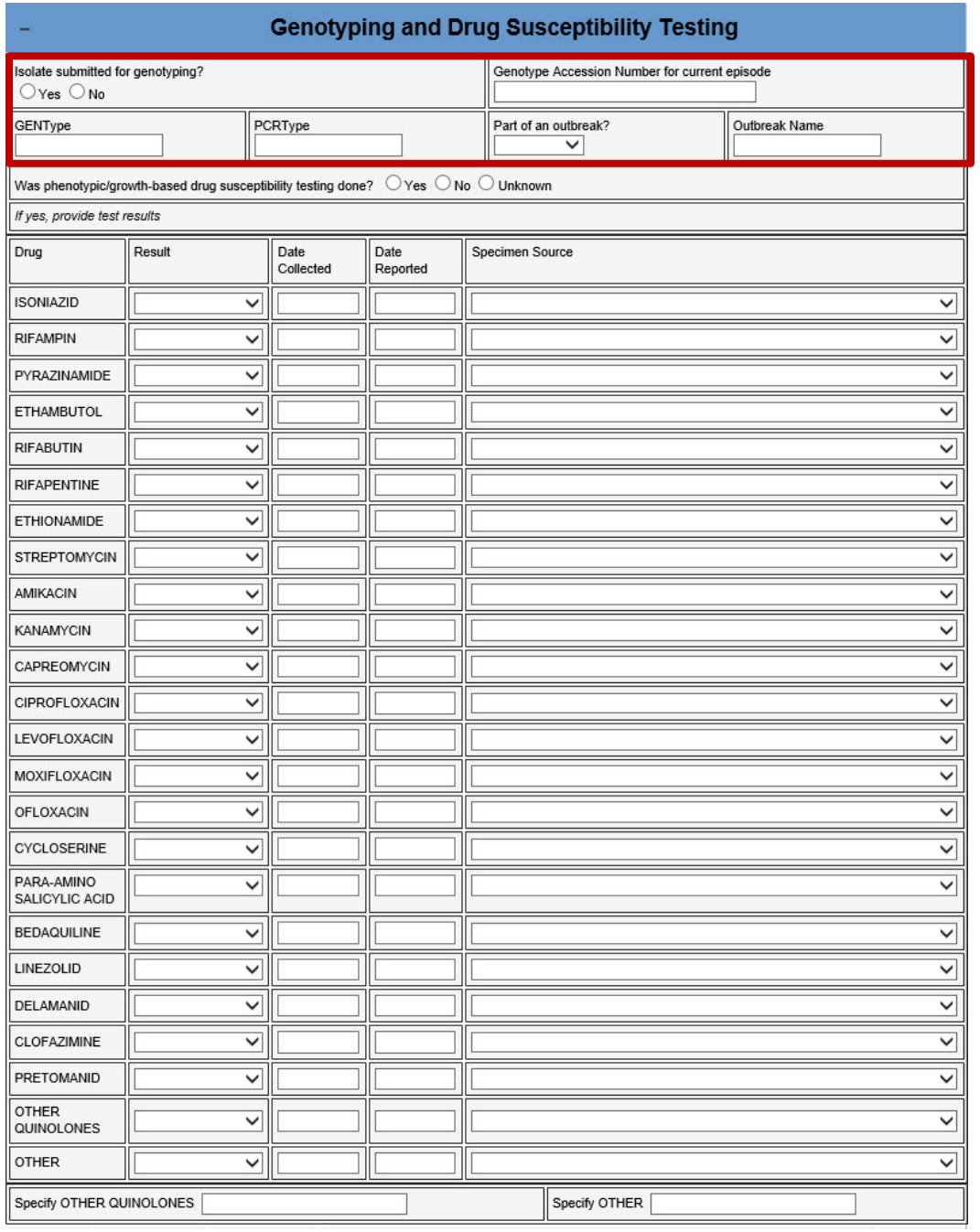
Was the Patient Treated as an MDR TB Case (Regardless of DST Results)?

Indicate whether an isolate was submitted for genotyping. If yes, enter the genotype accession number.

This will always be entered by the MDHHS TB Unit

Purpose: To link genotyping results with RVCT data

2020 RVCT Reference Manual pg. 55



Genotyping and Drug Susceptibility Testing

Isolate submitted for genotyping? ○ Yes ○ No

Genotype Accession Number for current episode

GENType | PCRType | Part of an outbreak? | Outbreak Name

Was phenotypic/growth-based drug susceptibility testing done? ○ Yes ○ No ○ Unknown

If yes, provide test results

Drug	Result	Date Collected	Date Reported	Specimen Source
ISONIAZID				
RIFAMPIN				
PYRAZINAMIDE				
ETHAMBUTOL				
RIFABUTIN				
RIFAPENTINE				
ETHIONAMIDE				
STREPTOMYCIN				
AMIKACIN				
KANAMYCIN				
CAPREOMYCIN				
CIPROFLOXACIN				
LEVOFLOXACIN				
MOXIFLOXACIN				
OFLOXACIN				
CYCLOSERINE				
PARA-AMINO SALICYLIC ACID				
BEDAQUILINE				
LINEZOLID				
DELAMANID				
CLOFAZIMINE				
PRETOMANID				
OTHER QUINOLONES				
OTHER				

Specify OTHER QUINOLONES | Specify OTHER

GENOTYPING & DRUG SUSCEPTIBILITY TESTING

Isolate Submitted for Genotyping?

Was Phenotypic/Growth-Based Drug Susceptibility Testing Done?

Was Genotyping/Molecular Drug Susceptibility Done?

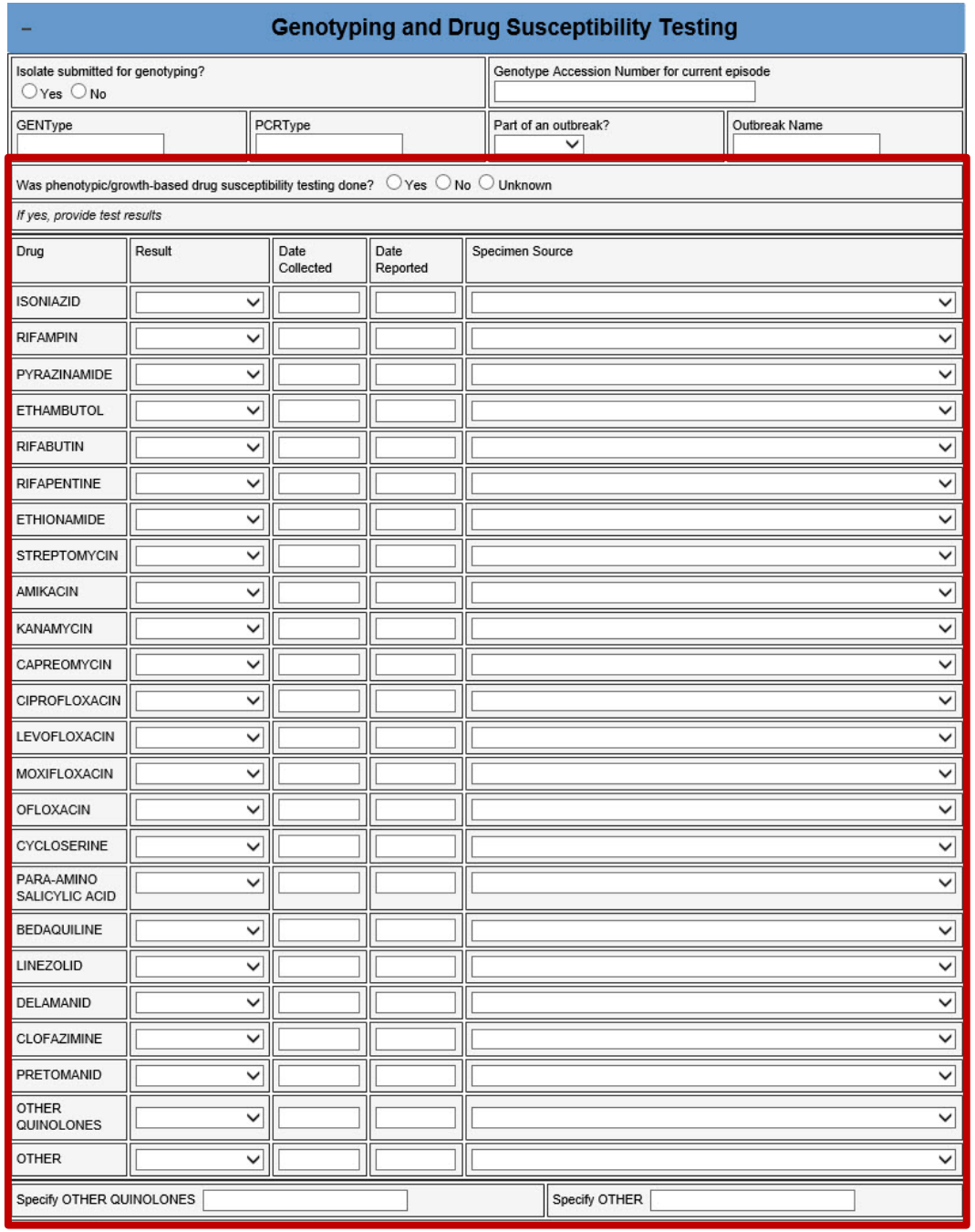
Was the Patient Treated as an MDR TB Case (Regardless of DST Results)?

Indicate whether growth-based DST was performed.
If yes, complete the table with result for each drug tested, specimen type, date collected, and date reported.

This will usually be entered by the MDHHS TB Unit

Purpose: To identify TB cases with drug-resistant isolates using phenotypic/growth-based drug susceptibility testing methods.

2020 RVCT Reference Manual pg. 56



Genotyping and Drug Susceptibility Testing

Isolate submitted for genotyping? ○ Yes ○ No	Genotype Accession Number for current episode
GENType	PCRType / Part of an outbreak? / Outbreak Name

Was phenotypic/growth-based drug susceptibility testing done? ○ Yes ○ No ○ Unknown

If yes, provide test results

Drug	Result	Date Collected	Date Reported	Specimen Source
ISONIAZID				
RIFAMPIN				
PYRAZINAMIDE				
ETHAMBUTOL				
RIFABUTIN				
RIFAPENTINE				
ETHIONAMIDE				
STREPTOMYCIN				
AMIKACIN				
KANAMYCIN				
CAPREOMYCIN				
CIPROFLOXACIN				
LEVOFLOXACIN				
MOXIFLOXACIN				
OFLOXACIN				
CYCLOSERINE				
PARA-AMINO SALICYLIC ACID				
BEDAQUILINE				
LINEZOLID				
DELAMANID				
CLOFAZIMINE				
PRETOMANID				
OTHER QUINOLONES				
OTHER				

Specify OTHER QUINOLONES | Specify OTHER

GENOTYPING & DRUG SUSCEPTIBILITY TESTING

Isolate Submitted for Genotyping?

Was Phenotypic/Growth-Based Drug Susceptibility Testing Done?

Was Genotyping/Molecular Drug Susceptibility Done?

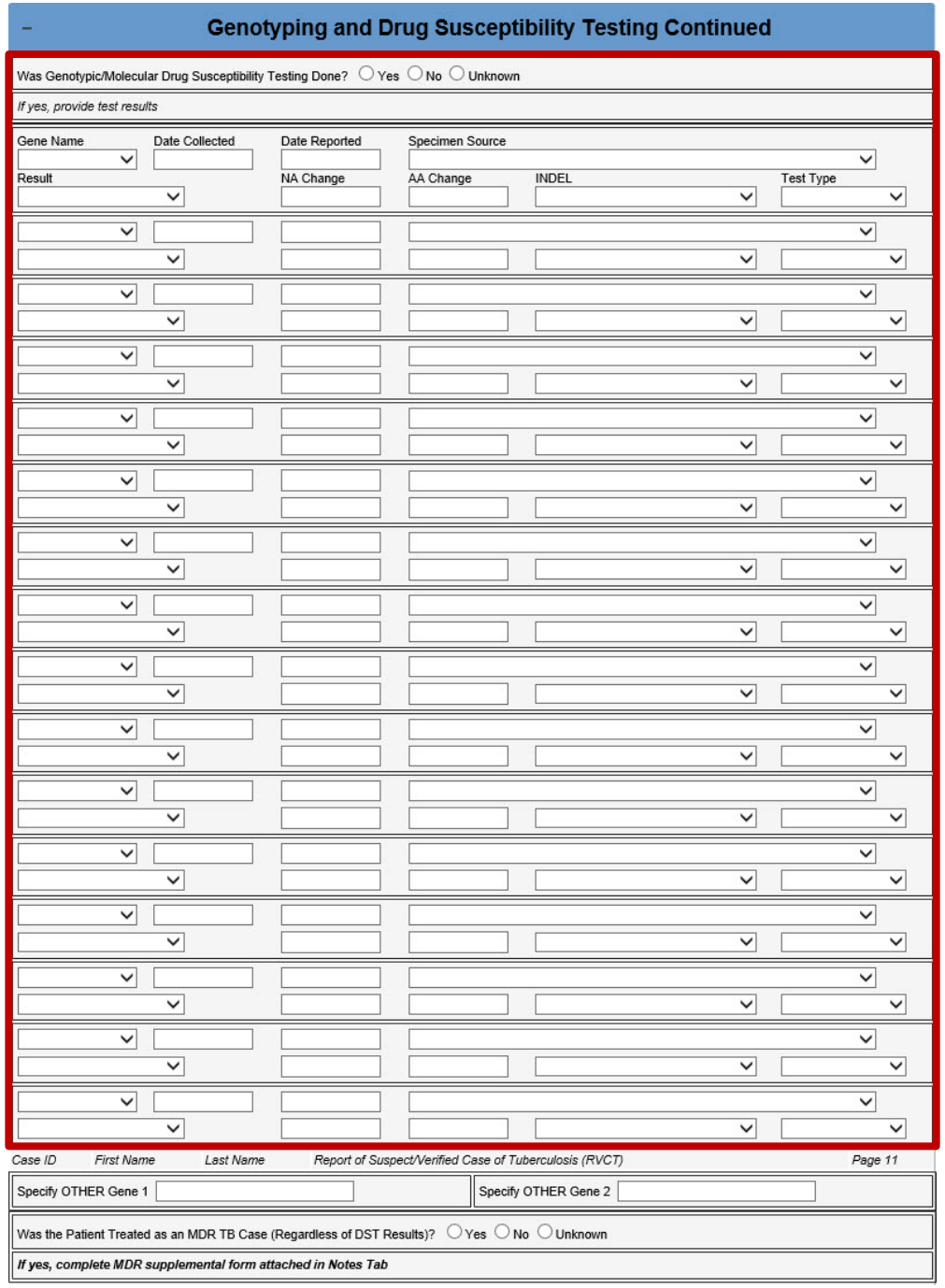
Was the Patient Treated as an MDR TB Case (Regardless of DST Results)?

Indicate whether molecular drug susceptibility testing was performed (i.e. MDDR or GeneXpert MTB/RIF).
If yes, complete the table for each gene tested.

This will always be entered by the MDHHS TB Unit

Purpose: Provides information on test results for genetic mutation associated with drug resistance.

2020 RVCT Reference Manual pg. 57-58



Genotyping and Drug Susceptibility Testing Continued

Was Genotypic/Molecular Drug Susceptibility Testing Done? ○ Yes ○ No ○ Unknown

If yes, provide test results

Gene Name	Date Collected	Date Reported	Specimen Source			
Result		NA Change	AA Change	INDEL	Test Type	

Case ID *First Name* *Last Name* *Report of Suspect/Verified Case of Tuberculosis (RVCT)* *Page 11*

Specify OTHER Gene 1 | Specify OTHER Gene 2

Was the Patient Treated as an MDR TB Case (Regardless of DST Results)? ○ Yes ○ No ○ Unknown

If yes, complete MDR supplemental form attached in Notes Tab

GENOTYPING & DRUG SUSCEPTIBILITY TESTING

Isolate Submitted for Genotyping?

Was Phenotypic/Growth-Based Drug Susceptibility Testing Done?

Was Genotyping/Molecular Drug Susceptibility Done?

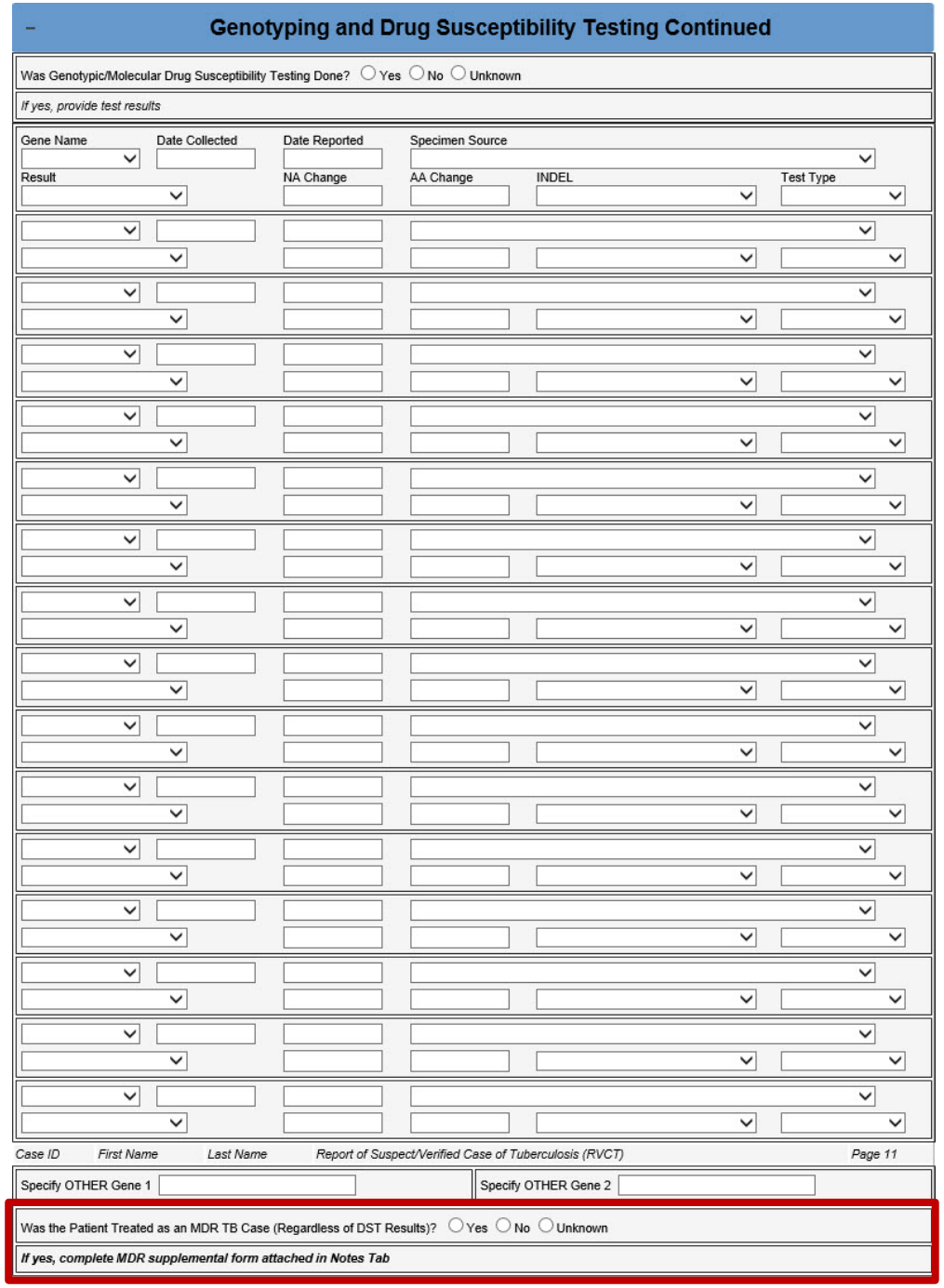
Was the Patient Treated as an MDR TB Case (Regardless of DST Results)?

Indicate whether the patient was treated as an MDR TB Case.

If yes, complete the supplemental form that will be attached in the "Notes" tab.

Purpose: To determine whether a patient was treated as a multidrug-resistance (MDR) TB case, regardless of laboratory results.

2020 RVCT Reference Manual pg. 59



Genotyping and Drug Susceptibility Testing Continued

Was Genotypic/Molecular Drug Susceptibility Testing Done? ○ Yes ○ No ○ Unknown

If yes, provide test results

Gene Name	Date Collected	Date Reported	Specimen Source		
Result		NA Change	AA Change	INDEL	Test Type

Case ID *First Name* *Last Name* *Report of Suspect/Verified Case of Tuberculosis (RVCT)* *Page 11*

Specify OTHER Gene 1 | Specify OTHER Gene 2

Was the Patient Treated as an MDR TB Case (Regardless of DST Results)? ○ Yes ○ No ○ Unknown

If yes, complete MDR supplemental form attached in Notes Tab

Genotyping and Drug Susceptibility Testing

Isolate submitted for genotyping?	Genotype Accession Number for current episode
(•) Yes ( ) No	20RF8888

GENType	PCRType	Part of an outbreak?	Outbreak Name
G88888	PCR88888	No	

Was phenotypic/growth-based drug susceptibility testing done? (•) Yes ( ) No ( ) Unknown

If yes, provide test results

Drug	Result	Date Collected	Date Reported	Specimen Source
ISONIAZID	SUSCEPTIBLE	06/01/2020	06/25/2020	Sputum
RIFAMPIN	SUSCEPTIBLE	06/01/2020	06/25/2020	Sputum
PYRAZINAMIDE	SUSCEPTIBLE	06/01/2020	06/25/2020	Sputum
ETHAMBUTOL	SUSCEPTIBLE	06/01/2020	06/25/2020	Sputum
RIFABUTIN	NOT DONE			
RIFAPENTINE	NOT DONE			
ETHIONAMIDE	NOT DONE			
STREPTOMYCIN	NOT DONE			
AMIKACIN	NOT DONE			
KANAMYCIN	NOT DONE			
CAPREOMYCIN	NOT DONE			
CIPROFLOXACIN	NOT DONE			
LEVOFLOXACIN	NOT DONE			
MOXIFLOXACIN	NOT DONE			
OFLOXACIN	NOT DONE			
CYCLOSERINE	NOT DONE			
PARA-AMINO SALICYLIC ACID	NOT DONE			
BEDAQUILINE	NOT DONE			
LINEZOLID	NOT DONE			
DELAMANID	NOT DONE			
CLOFAZIMINE	NOT DONE			
PRETOMANID	NOT DONE			
OTHER QUINOLONES	NOT DONE			
OTHER	NOT DONE			

Specify OTHER QUINOLONES	Specify OTHER

Genotyping and Drug Susceptibility Testing Continued

Was Genotypic/Molecular Drug Susceptibility Testing Done? ○ Yes ◉ No ○ Unknown

If yes, provide test results

Gene Name	Date Collected	Date Reported	Specimen Source		
Result		NA Change	AA Change	INDEL	Test Type

Specify OTHER Gene 1 | Specify OTHER Gene 2

Was the Patient Treated as an MDR TB Case (Regardless of DST Results)? ○ Yes ◉ No ○ Unknown

If yes, complete MDR supplemental form attached in Notes Tab

CASE OUTCOME

Sputum Culture Conversion Documented?

Moved During Therapy?

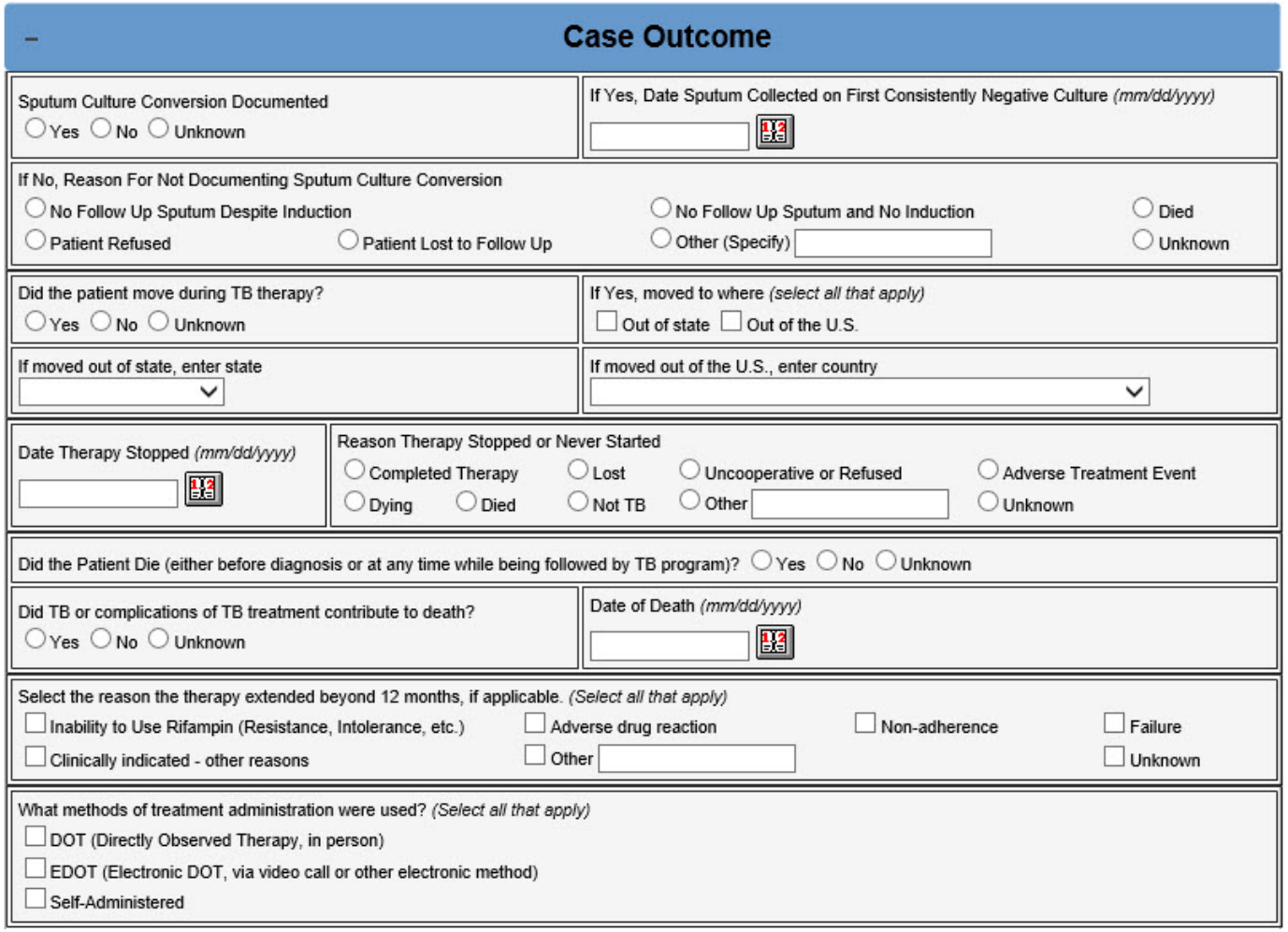
Date Therapy Stopped

Reason Therapy Stopped or Never Started?

Reason TB Disease Therapy Extended >12 Months, *if applicable*

Treatment Administration

Did the Patient Die (either before diagnosis or at any time while being follow by TB program)?



Case Outcome

Sputum Culture Conversion Documented
○ Yes ○ No ○ Unknown

If Yes, Date Sputum Collected on First Consistently Negative Culture *(mm/dd/yyyy)*

If No, Reason For Not Documenting Sputum Culture Conversion
○ No Follow Up Sputum Despite Induction ○ No Follow Up Sputum and No Induction ○ Died
○ Patient Refused ○ Patient Lost to Follow Up ○ Other (Specify) ○ Unknown

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

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

If moved out of state, enter state

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

Date Therapy Stopped *(mm/dd/yyyy)*

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

Did the Patient Die (either before diagnosis or at any time while being followed by TB program)? ○ Yes ○ No ○ Unknown

Did TB or complications of TB treatment contribute to death?
○ Yes ○ No ○ Unknown

Date of Death *(mm/dd/yyyy)*

Select the reason the therapy extended beyond 12 months, if applicable. *(Select all that apply)*
☐ Inability to Use Rifampin (Resistance, Intolerance, etc.) ☐ Adverse drug reaction ☐ Non-adherence ☐ Failure
☐ Clinically indicated - other reasons ☐ Other ☐ Unknown

What methods of treatment administration were used? *(Select all that apply)*
☐ DOT (Directly Observed Therapy, in person)
☐ EDOT (Electronic DOT, via video call or other electronic method)
☐ Self-Administered

CASE OUTCOME

Sputum Culture Conversion Documented?

Moved During Therapy?

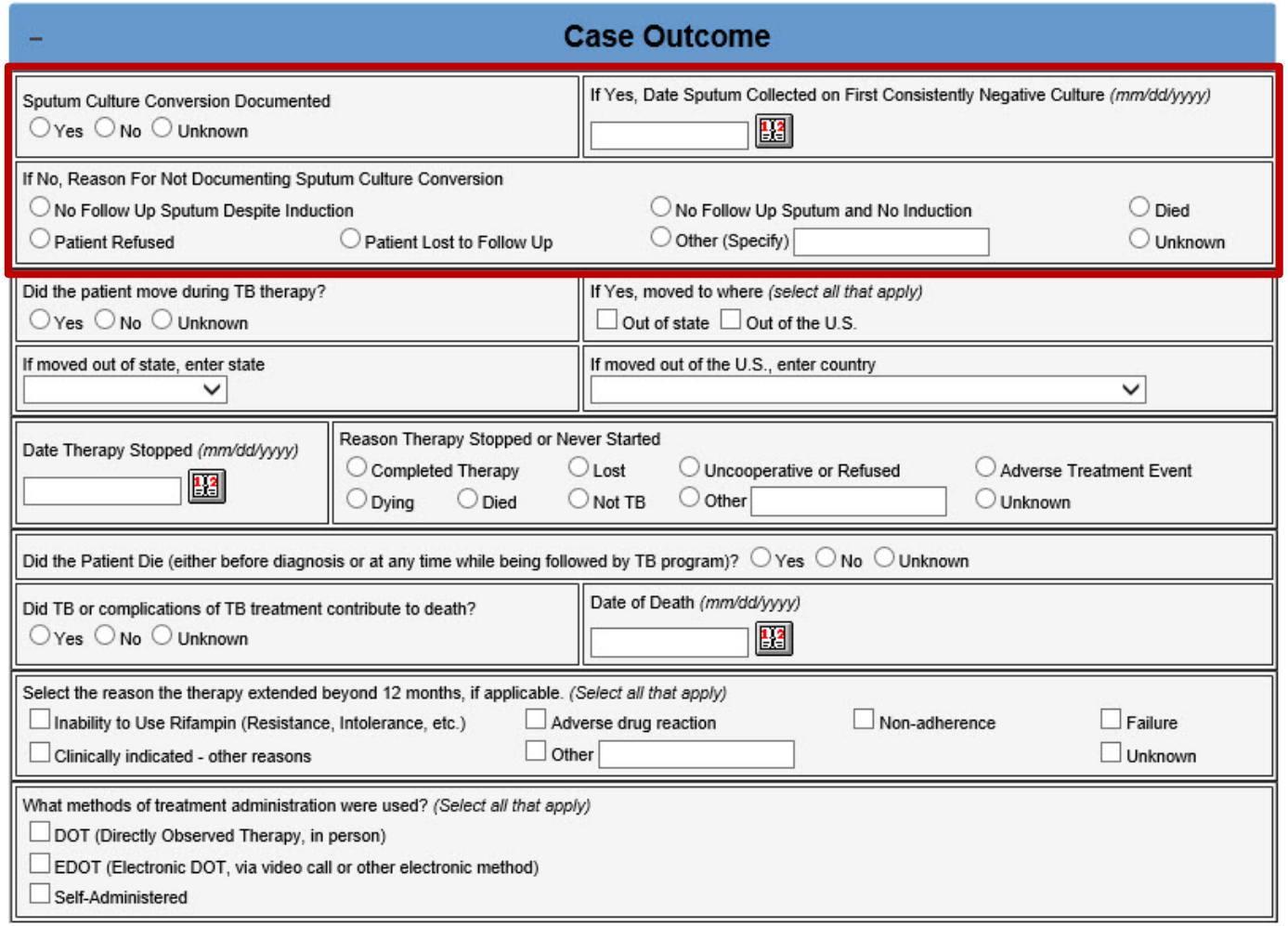
Date Therapy Stopped

Reason Therapy Stopped or Never Started?

Reason TB Disease Therapy Extended >12 Months, *if applicable*

Treatment Administration

Did the Patient Die (either before diagnosis or at any time while being follow by TB program)?



Only for cases where the initial sputum specimen was culture-positive, indicate if it was followed by at least one negative sputum culture (not within initial set of sputa).
If yes, enter the date the first negative specimen was collected. If no, select the reason for not documenting sputum culture conversion.

Purpose: To monitor the rate of sputum culture conversion

2020 RVCT Reference Manual pg. 60-61

CASE OUTCOME

Sputum Culture Conversion Documented?

Moved During Therapy?

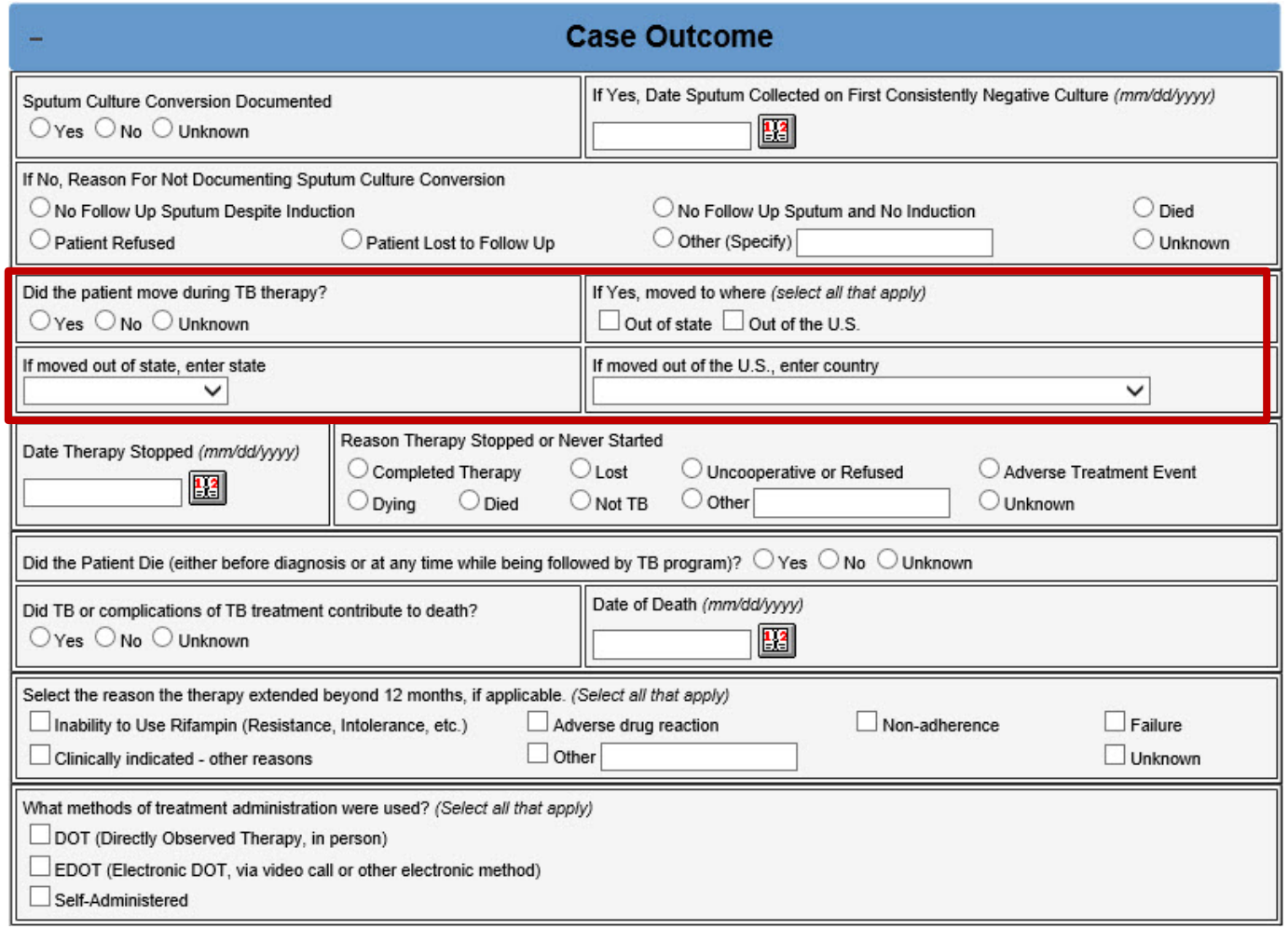
Date Therapy Stopped

Reason Therapy Stopped or Never Started?

Reason TB Disease Therapy Extended >12 Months, *if applicable*

Treatment Administration

Did the Patient Die (either before diagnosis or at any time while being follow by TB program)?



Indicate if the patient moved to another reporting area (state or country) during TB treatment.
If yes, indicate whether out of state and/or out of the U.S.
Specify the state and/or country.

Purpose: To facilitate efficient communication between TB control programs in providing continuity of care for the patient.

2020 RVCT Reference Manual pg. 62-63

CASE OUTCOME

Sputum Culture Conversion Documented?

Moved During Therapy?

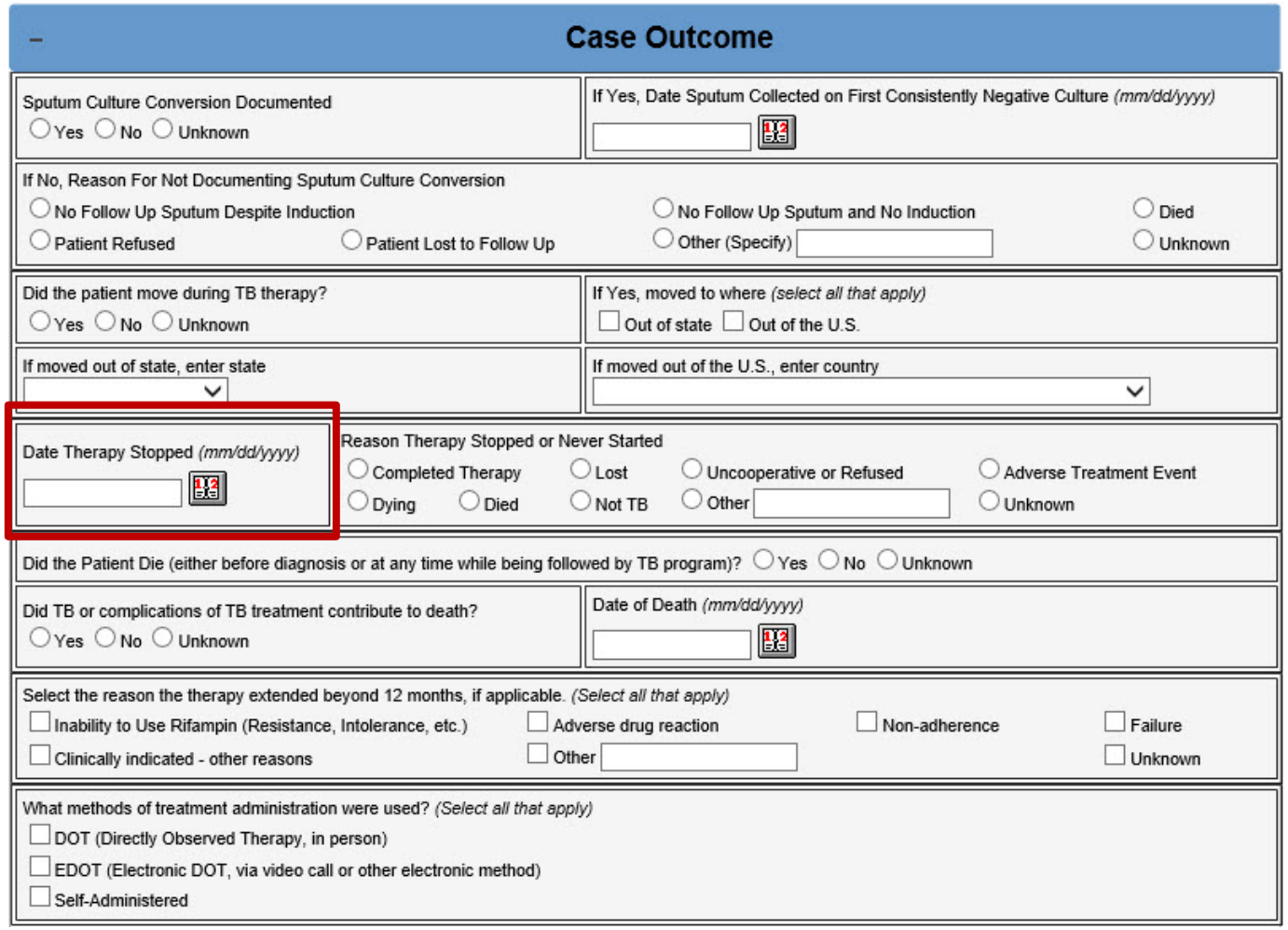
Date Therapy Stopped

Reason Therapy Stopped or Never Started?

Reason TB Disease Therapy Extended >12 Months, *if applicable*

Treatment Administration

Did the Patient Die (either before diagnosis or at any time while being follow by TB program)?



Date the patient stopped taking medication for confirmed or possible TB disease.

May be one of several dates, ideally, when the patient last ingested medication if documented in a medical record.

Purpose: To monitor completion of therapy within a specific time

2020 RVCT Reference Manual pg. 64

CASE OUTCOME

Sputum Culture Conversion Documented?

Moved During Therapy?

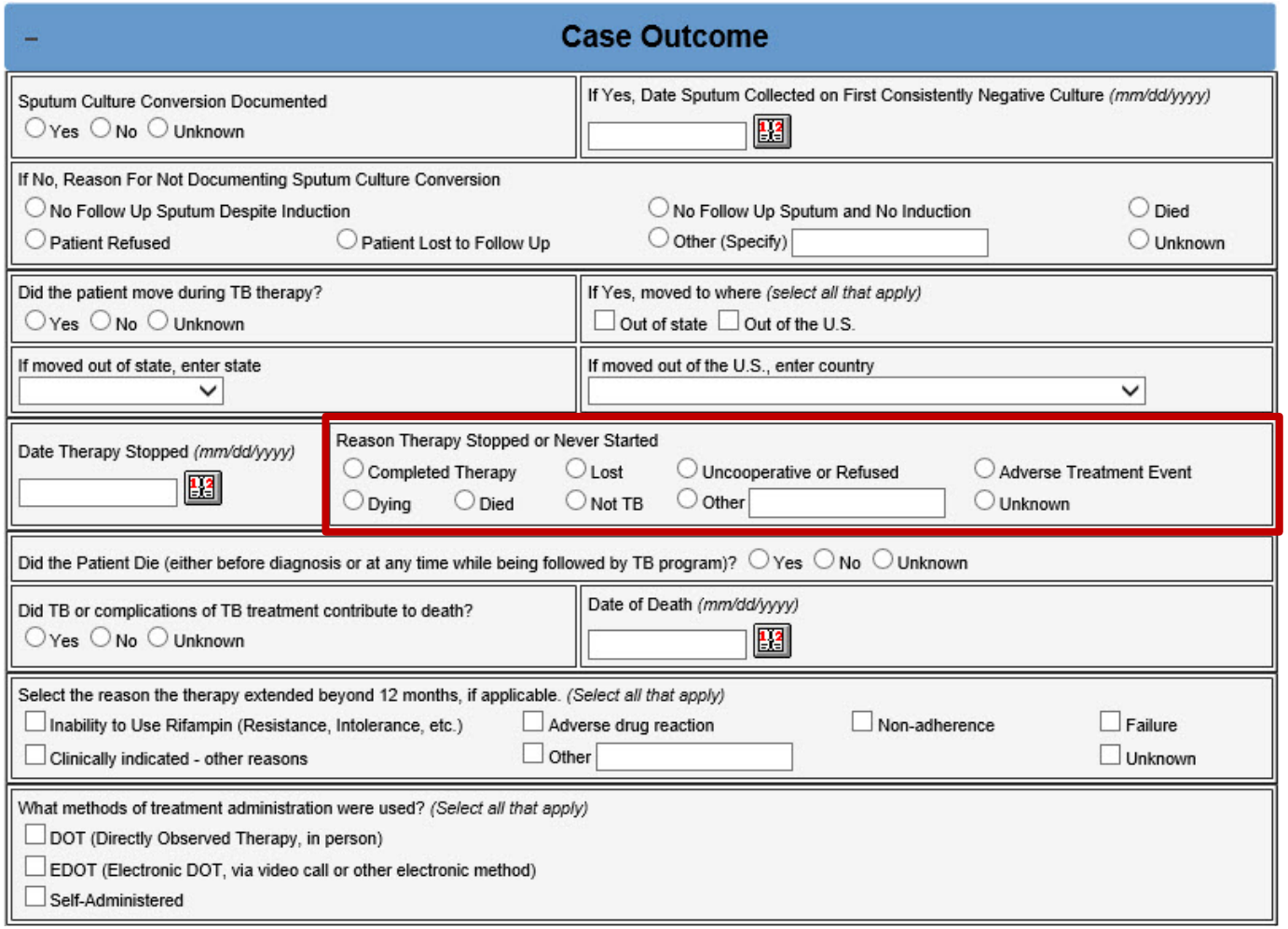
Date Therapy Stopped

Reason Therapy Stopped or Never Started?

Reason TB Disease Therapy Extended >12 Months, *if applicable*

Treatment Administration

Did the Patient Die (either before diagnosis or at any time while being follow by TB program)?



Indicate the reason TB therapy was stopped or never started. Usually this is "completed therapy."

"Other" should be used if patient moved out of state or country and treatment outcome can not be obtained despite attempts.

Purpose: To document treatment outcome

2020 RVCT Reference Manual pg. 65

CASE OUTCOME

Sputum Culture Conversion Documented?

Moved During Therapy?

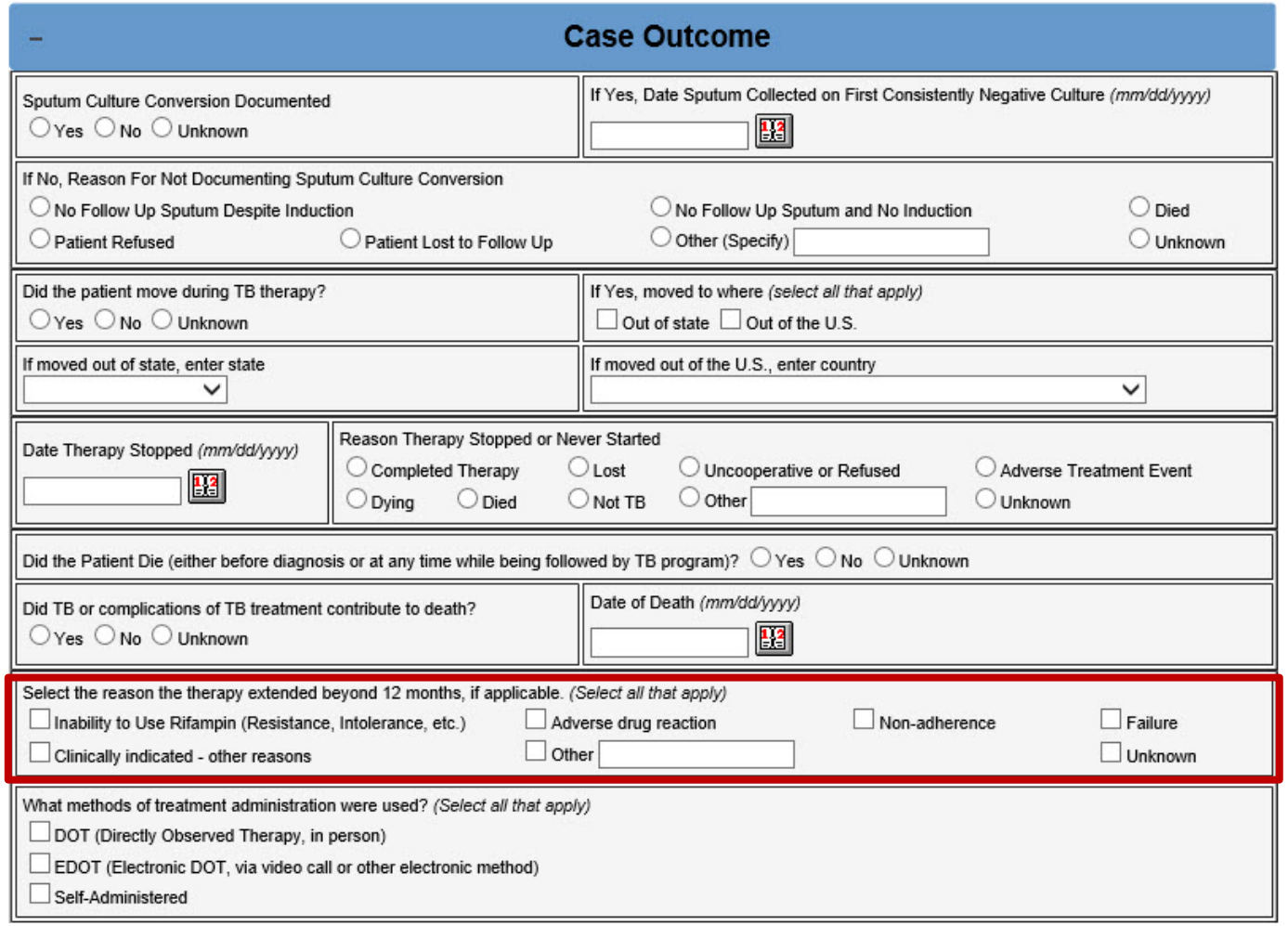
Date Therapy Stopped

Reason Therapy Stopped or Never Started?

Reason TB Disease Therapy Extended >12 Months, *if applicable*

Treatment Administration

Did the Patient Die (either before diagnosis or at any time while being follow by TB program)?



If TB therapy extended beyond 12 months, specify the reason(s) why.

Purpose: To document reason for extended treatment and to calculate program indicators

2020 RVCT Reference Manual pg. 66

CASE OUTCOME

Sputum Culture Conversion Documented?

Moved During Therapy?

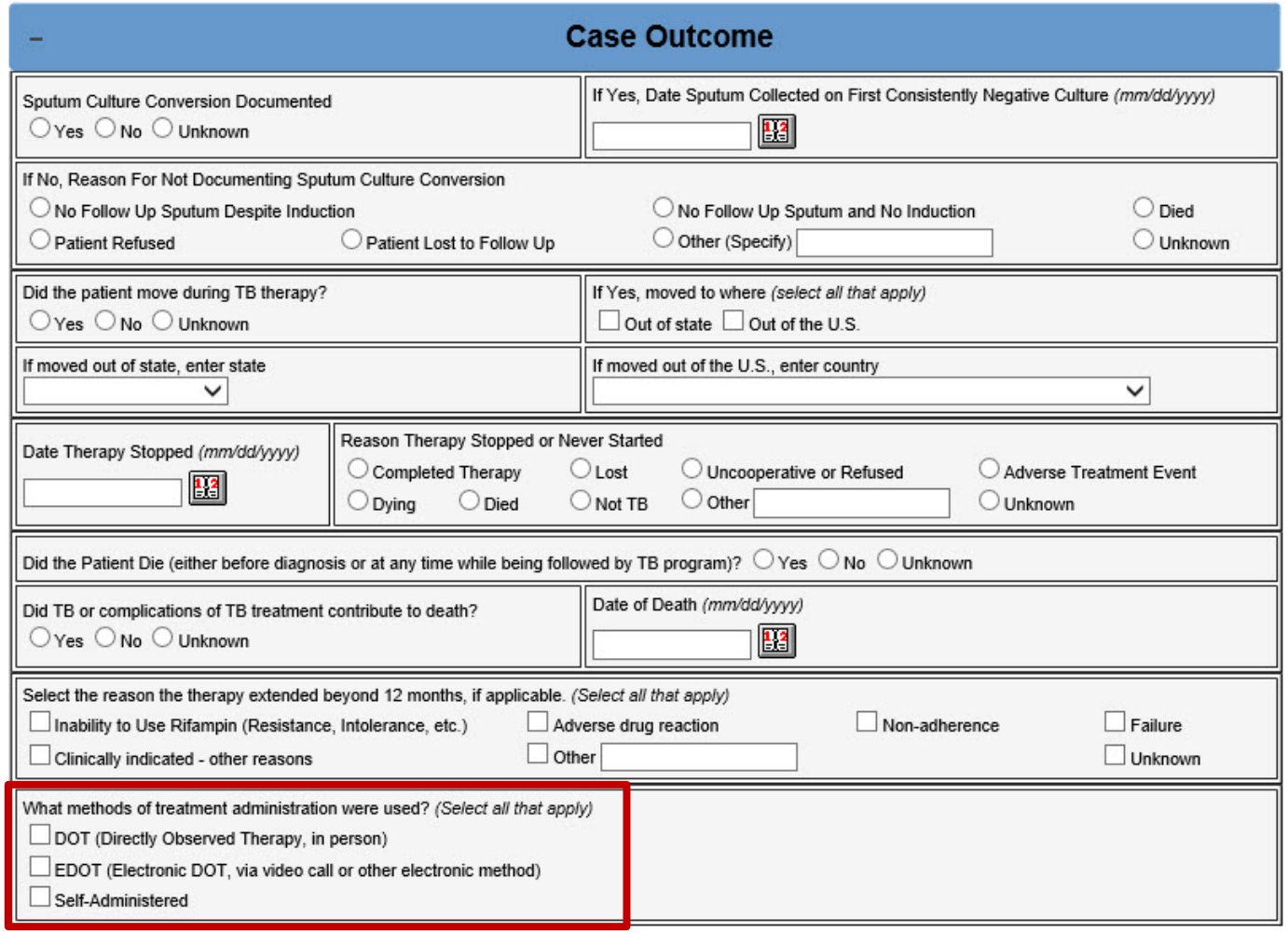
Date Therapy Stopped

Reason Therapy Stopped or Never Started?

Reason TB Disease Therapy Extended >12 Months, *if applicable*

Treatment Administration

Did the Patient Die (either before diagnosis or at any time while being follow by TB program)?



Specify what method(s) of treatment administration were used during the course of TB therapy.

Purpose: To document administration of TB medications.

2020 RVCT Reference Manual pg. 67

CASE OUTCOME

Sputum Culture Conversion Documented?

Moved During Therapy?

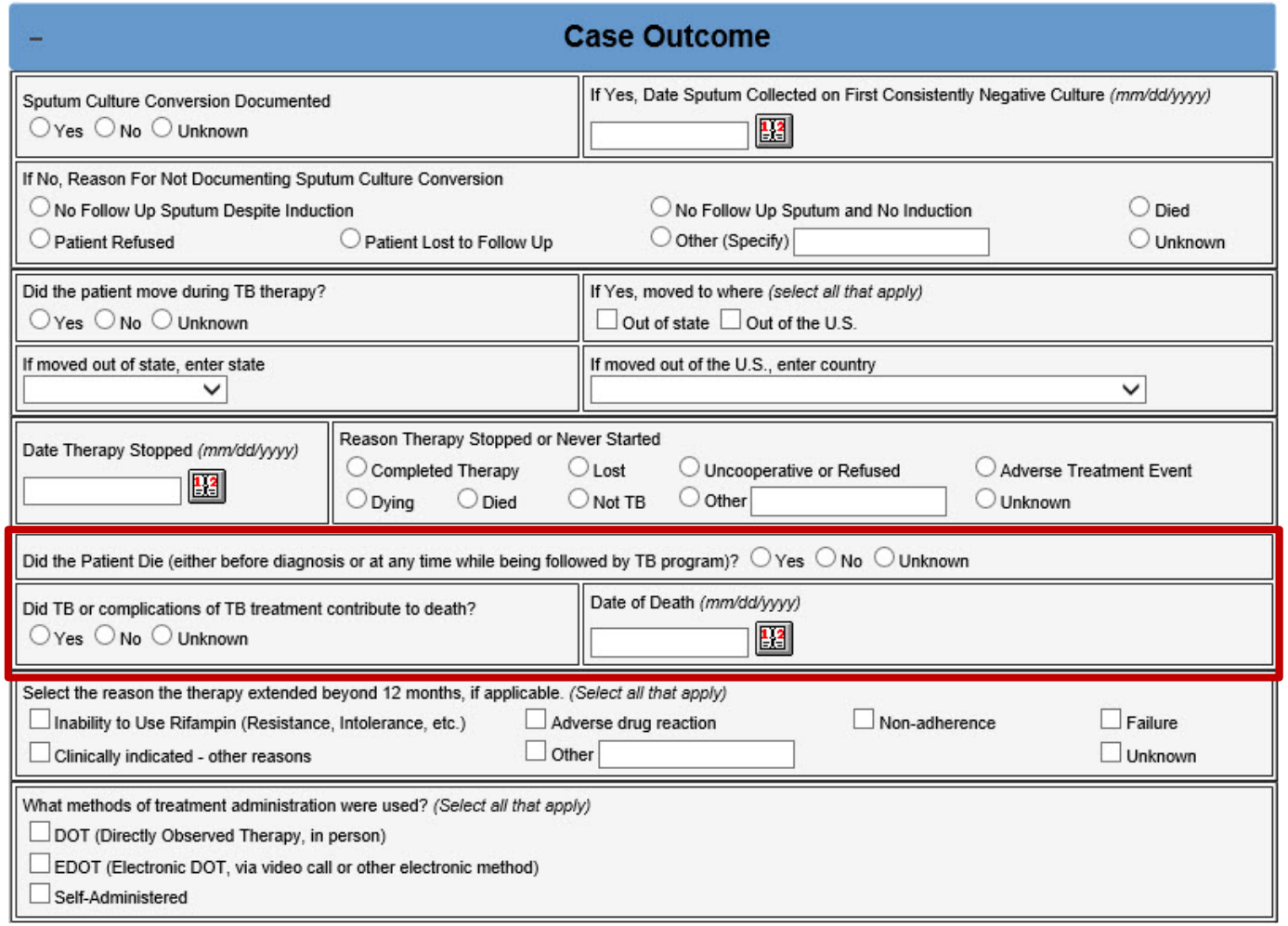
Date Therapy Stopped

Reason Therapy Stopped or Never Started?

Reason TB Disease Therapy Extended >12 Months, *if applicable*

Treatment Administration

Did the Patient Die (either before diagnosis or at any time while being follow by TB program)?



Indicate whether the patient died for any reason either before TB diagnosis or at any point after TB diagnosis while the TB program was following the patient.
If yes, enter Date of Death and select whether TB or complication of TB treatment contributed to the death.

Purpose: To collect information on mortality among TB patients.

2020 RVCT Reference Manual pg. 68-69

Case Outcome

Sputum Culture Conversion Documented
(●) Yes ( ) No ( ) Unknown

If Yes, Date Sputum Collected on First Consistently Negative Culture *(mm/dd/yyyy)*
02/01/2020

If No, Reason For Not Documenting Sputum Culture Conversion
( ) No Follow Up Sputum Despite Induction
( ) No Follow Up Sputum and No Induction
( ) Died
( ) Patient Refused
( ) Patient Lost to Follow Up
( ) Other (Specify)
( ) Unknown

Did the patient move during TB therapy?
( ) Yes (●) No ( ) Unknown

If Yes, moved to where *(select all that apply)*
[ ] Out of state [ ] Out of the U.S.

If moved out of state, enter state

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

Date Therapy Stopped *(mm/dd/yyyy)*
06/25/2020

Reason Therapy Stopped or Never Started
(●) Completed Therapy
( ) Lost
( ) Uncooperative or Refused
( ) Adverse Treatment Event
( ) Dying
( ) Died
( ) Not TB
( ) Other
( ) Unknown

Did the Patient Die (either before diagnosis or at any time while being followed by TB program)? ( ) Yes ( ) No ( ) Unknown

Did TB or complications of TB treatment contribute to death?
( ) Yes ( ) No ( ) Unknown

Date of Death *(mm/dd/yyyy)*

Select the reason the therapy extended beyond 12 months, if applicable. *(Select all that apply)*
[ ] Inability to Use Rifampin (Resistance, Intolerance, etc.)
[ ] Adverse drug reaction
[ ] Non-adherence
[ ] Failure
[ ] Clinically indicated - other reasons
[ ] Other
[ ] Unknown

What methods of treatment administration were used? *(Select all that apply)*
[x] DOT (Directly Observed Therapy, in person)
[x] EDOT (Electronic DOT, via video call or other electronic method)
[ ] Self-Administered

TUBERCULOSIS CASE DEFINITION FOR PUBLIC HEALTH SURVEILLANCE

Clinical description

A chronic bacterial infection caused by *Mycobacterium tuberculosis*, usually characterized pathologically by the formation of granulomas. The most common site of infection is the lung, but other organs may be involved.

Clinical criteria

A case that meets all the following criteria:

- A positive tuberculin skin test or positive interferon gamma release assay for *M. tuberculosis*
- Other signs and symptoms compatible with tuberculosis (TB) (e.g., abnormal chest radiograph, abnormal chest computerized tomography scan or other chest imaging study, or clinical evidence of current disease)
- Treatment with two or more anti-TB medications
- A completed diagnostic evaluation

Laboratory criteria for diagnosis

- Isolation of *M. tuberculosis* from a clinical specimen,* *OR*
- Demonstration of *M. tuberculosis* complex from a clinical specimen by nucleic acid amplification test,** *OR*
- Demonstration of acid-fast bacilli in a clinical specimen when a culture has not been or cannot be obtained or is falsely negative or contaminated.

Case classification

Confirmed

A case that meets the clinical case definition or is laboratory confirmed.

Questions?

THANK YOU!

Email smiths79@michigan.gov
with questions or concerns