Patient's Name _____ _____ _____ _____

Last First M.I. MEDSIS ID

# REPORT OF VERIFIED CASE OF TUBERCULOSIS (RVCT): INITIAL

## Dates

**Date Reported** Month / Day / Year

**Date Submitted** Month / Day / Year

**Date Counted** Month / Day / Year

**MMWR Week** _____ **MMWR Year** _____

**Date Illness/ Symptom Onset** Month / Day / Year

## Case Numbers

| | Year Reported (YYYY) | State Code | Locally Assigned Identification Number |
|---|---|---|---|
| **State Case Number** | | | |
| **City/County Case Number** | | | |

**Does the patient have any epidemiological linkage?** ☐Yes ☐No

| | | | |
|---|---|---|---|
| **Epi-Linked Case Number** | | | |
| **Epi-Linked Case Number** | | | |
| **Epi-Linked Case Number** | | | |
| **Epi-Linked Case Number** | | | |

## Reporting Address

**Inside City Limits?** ☐Yes ☐No

**Street** _____

**City** _____ **State** _____ **Zip** _____

**County** _____ **Census Tract** _____

## Demographics

**Date of Birth** Month / Day / Year

**Sex at Birth** ☐Male ☐Female

If Female, Pregnant at Time of Dx? ☐Yes ☐No

**Ethnicity** (*select one*)
- ☐Hispanic or Latino
- ☐Not Hispanic or Latino

**Country of Birth** _____

**Eligible for US citizenship at birth?** ☐Yes ☐No

**Race**
- ☐American Indian *or* Alaskan Native
- ☐Asian: *Specify* _____
- ☐Black *or* African American
- ☐Native Hawaiian *or* Other Pacific Islander: *Specify* _____
- ☐White

**Date of First US Arrival** Month / Day / Year

**Primary Guardian(s) Country of Birth** (*if Patient <15 y.o.*)

1) _____

2) _____

## Previous Disease History

**History of TB or LTBI?** ☐No ☐Yes

| | Type | Prior Diagnosis Date (Month / Day / Year) | Completed Treatment? | Prior Case Number |
|---|---|---|---|---|
| 1 | ☐TB ☐LTBI | | ☐Yes ☐No | |
| 2 | ☐TB ☐LTBI | | ☐Yes ☐No | |
| 3 | ☐TB ☐LTBI | | ☐Yes ☐No | |
| 4 | ☐TB ☐LTBI | | ☐Yes ☐No | |

## Site of TB Disease

1) _____

2) _____

3) _____

4) _____

## Chest Radiograph and Other Chest Imaging Studies

**CXR**

**Chest Radiograph Performed?** ☐Yes ☐No — Month / Day / Year

☐Consistent with TB ☐Not Consistent with TB

**Evidence of Cavity** ☐Yes ☐No **Miliary TB** ☐Yes ☐No

**CT**

**Chest CT Performed?** ☐Yes ☐No — Month / Day / Year

☐Consistent with TB ☐Not Consistent with TB

**Evidence of Cavity** ☐Yes ☐No **Miliary TB** ☐Yes ☐No

**Other**

**Other Imaging Performed?** — Month / Day / Year

**Type** _____

☐Consistent with TB ☐Not Consistent with TB

**Evidence of Cavity** ☐Yes ☐No **Miliary TB** ☐Yes ☐No

**Other**

**Other Imaging Performed?** — Month / Day / Year

**Type** _____

☐Consistent with TB ☐Not Consistent with TB

**Evidence of Cavity** ☐Yes ☐No **Miliary TB** ☐Yes ☐No

## Status at TB Diagnosis

(*select one*)

☐Alive ☐Dead

## Initial Reason Evaluated

*Options are in order; pick first option that matches reason for patient evaluation*

- ☐Contact Investigation
- ☐Screening
- ☐TB symptoms
- ☐Other

ADHS

Patient's Name _____ _____

Last First M.I. MEDSIS ID

# RVCT: INITIAL

## Risk Factors

**Lived outside US** (*>60 consecutive days*) ☐Yes ☐No ☐Unknown

**Meets Binational Criteria** ☐Yes ☐No ☐Unknown

**Resident of Correctional Facility Ever** ☐Yes ☐No ☐Unknown

**Resident of Corrections at Evaluation** ☐Yes ☐No ☐Unknown

**Corr. Facility Type** _____

**ICE Custody** ☐Yes ☐No

**Injection Drug Use, past 12-mo** ☐Yes ☐No ☐Unknown

**Non-Injection Drug Use, past 12-mo** ☐Yes ☐No ☐Unknown

**Heavy Alcohol Use, past 12-mo** ☐Yes ☐No ☐Unknown

**Identified during Contact Investigation** ☐Yes ☐No ☐Unknown

**Evaluated during C.I.** ☐Yes ☐No ☐Unknown

**Homeless Ever** ☐Yes ☐No ☐Unknown

**Homeless in past 12-mo** ☐Yes ☐No ☐Unknown

**Long-Term Care Resident at Dx** ☐Yes ☐No ☐Unknown

**LTC Facility Type** _____

**Smoking Status** ☐Current Every Day ☐Current Some Days ☐Former ☐Smoker, Current Unknown ☐Never ☐Unknown

**HIV Status** ☐Positive ☐Negative ☐Indeterminate ☐Not Offered ☐Refused ☐Unknown

State HIV/AIDS Case # _____ Local HIV/AIDS Case # _____

## Additional Risk Factors

**Diabetes Mellitus** ☐Yes ☐No ☐Unknown

**TNF-α Antagonist Therapy** ☐Yes ☐No ☐Unknown

**End-Stage Renal Disease** ☐Yes ☐No ☐Unknown

**Other Immunocompromise** (not HIV/AIDS) ☐Yes ☐No ☐Unknown

**Post-Organ Transplant** ☐Yes ☐No ☐Unknown

**Viral Hep type B or C** ☐Yes ☐No ☐Unknown

**Coccidioidomycosis** (Valley Fever) ☐Yes ☐No ☐Unknown

**Other** (*specify*) _____

## Occupation

**Ever worked as:** ☐Health care worker ☐Correctional facility employee ☐Migrant/seasonal worker ☐None of the above ☐Unknown

If patient ≥ 14 years of age: **Current Occupation** _____ **Current Industry** _____

If different from above: **Longest Occupation** _____ **Longest Industry** _____

## Initial Treatment Regimen

**Date Therapy Started** Month ____ Day ____ Year ____

**If not RIPE, reason:**

☐Suspected Resistance
☐DST already known
☐Drug Contraindication/Interaction
☐Drug Shortage
☐Other (*specify*) _____

| | No | Yes | Unk | | No | Yes | Unk |
|---|---|---|---|---|---|---|---|
| Isoniazid | ☐ | ☐ | ☐ | Ethionamide | ☐ | ☐ | ☐ |
| Rifampin | ☐ | ☐ | ☐ | Kanamycin | ☐ | ☐ | ☐ |
| Pyrazinamide | ☐ | ☐ | ☐ | Levofloxacin | ☐ | ☐ | ☐ |
| Ethambutol | ☐ | ☐ | ☐ | Linezolid | ☐ | ☐ | ☐ |
| Amikacin | ☐ | ☐ | ☐ | Moxifloxacin | ☐ | ☐ | ☐ |
| PAS | ☐ | ☐ | ☐ | Ofloxacin | ☐ | ☐ | ☐ |
| Bedaquiline | ☐ | ☐ | ☐ | Other Quinolones | ☐ | ☐ | ☐ |
| Capreomycin | ☐ | ☐ | ☐ | Pretomanid | ☐ | ☐ | ☐ |
| Ciprofloxacin | ☐ | ☐ | ☐ | Rifabutin | ☐ | ☐ | ☐ |
| Clofazimine | ☐ | ☐ | ☐ | Rifapentine | ☐ | ☐ | ☐ |
| Cycloserine | ☐ | ☐ | ☐ | Streptomycin | ☐ | ☐ | ☐ |
| Delamanid | ☐ | ☐ | ☐ | Other | ☐ | ☐ | ☐ |

*specify* _____

**Comments:**

## Contact Investigation/Evaluation

**Was a C.I. done?** ☐Yes ☐No ☐Unknown

## Genotypic and Drug Susceptibilities

**Submitted for genotyping?** ☐Yes ☐No

**TB GIMS Accession** _____

1 **Type** _____ **Result** _____

2 **Type** _____ **Result** _____

3 **Type** _____ **Result** _____

**Comments:**

ADHS

Patient's Name _____ _____

Last First M.I. MEDSIS ID

# RVCT: Labs & Observations Section

## TST

☐ Not Done

**Plant Date** Month / Day / Year _____

**Read Date** Month / Day / Year _____

☐ Positive ☐ Negative

**Induration** (mm) _____

## IGRA

☐ Not Done

**Collection Date** Month / Day / Year _____

**Result Date** Month / Day / Year _____

☐ Positive ☐ Negative ☐ Indeterminate

**Test Type** (specify) _____

## Sputum Smear

**First Sputum Collected, Regardless of Result**

☐ Not Done

**Collection Date** Month / Day / Year _____

**Result Date** Month / Day / Year _____

☐ Positive ☐ Negative

****First smear positive sputum, if different from above**

**Collection Date** Month / Day / Year _____

**Result Date** Month / Day / Year _____

## Sputum Culture

**First Sputum Collected, Regardless of Result**

☐ Not Done

**Collection Date** Month / Day / Year _____

**Result Date** Month / Day / Year _____

☐ Positive ☐ Negative

****First MTB Culture positive sputum, if different from above**

**Collection Date** Month / Day / Year _____

**Result Date** Month / Day / Year _____

## NAA

**First NAA Collected**

☐ Not Done

**Collection Date** Month / Day / Year _____

**Result Date** Month / Day / Year _____

☐ Positive ☐ Negative

**Specimen Type** (specify) _____

****First positive NAA, if different from above**

**Collection Date** Month / Day / Year _____

**Result Date** Month / Day / Year _____

**Specimen Type** (specify) _____

## Drug Susceptibility Testing Performed

**Phenotypic** ☐ Yes ☐ No

**Molecular** ☐ Yes ☐ No

## Non-Sputum Diagnostic Labs of Interest

****Include first positives from non-sputum specimens**

| Test Type (smear/pathology/culture) | Specimen Type | Collection Date | Result Date | Test Result |
|---|---|---|---|---|
| | | / / | / / | |
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ADHS