**WV-DTBE**

# REPORT OF VERIFIED CASE OF TUBERCULOSIS

**NAME**_____ **TELEPHONE #**_____

**ADDRESS:**_____ **SEX:**____M ____F **DATE OF BIRTH:**_____

_____ZIP_____COUNTY_____

Within City Limits: ___Yes ___No

**HOMELESS WITHIN PAST YEAR:** ____Yes ____No.

**RACE:** ____Amer.Ind/Alask.Nav. _____Asian: *Specify*_____

____Black ____Nav.Haw/Pac.Is: *Specify*_____ White_____

**ETHNIC ORIGIN:** _____Hispanic _____Non-Hispanic

**SITE OF DISEASE:** **Previous Dx of TB? ___Yes ___No**

_____ Pulmonary _____ Lymphatic: Cervical

_____ Pleural _____ Lymphatic: Intrathoracic

_____ Laryngeal _____ Lymphatic: Axillary

_____ Bone / Joint _____ Lymphatic: Other

_____ Genitourinary _____ Peritoneal

_____ Meningeal _____ Other (Specify) _____

**COUNTRY OF BIRTH:**

_____ U.S.-BORN (or born abroad to U.S. citizen.)

_____ Other (Specify)_____

**Month/Year Arrived in U.S.** _____

**PEDIATRIC TB PATIENTS** (< 15 y/o)

Country of Birth for Primary Guardian(s): *Specify*

Guardian 1_____

Guardian 2_____

**Patient** lived outside US > 2 mos? _____Yes _____No

If YES, list countries, *specify*:_____

**STATUS AT TB DIAGNOSIS:** _____ Alive _____ Dead

If DEAD, date of death:_____.

TB cause of death? ____ Yes ____ No

**SPUTUM:** Smear: _____ Positive Culture: _____Positive Result Type of Lab: _____Public Health

Collected:_____ _____ Negative _____Negative Reported:_____ _____Commercial

_____ Not Done _____Not Done _____Other

**TISSUE AND OTHER BODY FLUIDS:** **Specimen type:**_____ **Collected:**_____

Type of Exam: ____Positive Culture: ____Positive Result Type of Lab: _____Public Health

____Smear ____Negative ____Negative Reported:_____ _____Commercial

____Pathology/Cytology ____Not Done ____Not Done _____Other

**NUCLEIC ACID AMPLIFICATION TEST RESULT:** **Specimen type:**_____

_____ Positive _____ Indeterminate Collected:_____ Type of Lab: _____Public Health

_____ Negative _____ Not Done Reported:_____ _____Commercial _____Other

**INITIAL CHEST RADIOGRAPH AND OTHER CHEST IMAGING STUDY**

**Chest X-ray:** DATE:_____ _____ Normal _____ Abnormal (consistent with TB) _____Not Done

For ABNORMAL Initial Chest X-ray: Evidence of a **Cavity**? ____Yes ____No; Evidence of **miliary** TB? ____Yes ____No

**Other Chest Imaging:** DATE:_____ _____ Normal _____ Abnormal (consistent with TB) _____Not Done

For ABNORMAL Initial Chest X-ray: Evidence of a Cavity? ____Yes ____No; Evidence of miliary TB? ____Yes ____No

**TUBERCULIN (Mantoux) SKIN TEST AT DIAGNOSIS:**

_____Positive _____ mms Date given:_____

_____Negative _____ Not Done

**INTERFERON GAMMA RELEASE ASSAY FOR MTB AT DIAGNOSIS:**

_____Positive ____Indeterminate Collected:_____

_____Negative ____Not Done Type_____

**HIV STATUS AT TIME OF DIAGNOSIS:** *(select one)*

____Negative ____Indeterminate ____Not Offered

____Positive ____Refused ____Test Done, Results Unknown

If POSITIVE, enter State HIV/AIDS #: __ __ __ __ __ __ __ __ __ __

**PRIMARY REASON EVALUATED FOR TB DISEASE** (*select one*):

____ TB Symptoms

____ Abn. CXR (consistent with TB)

____ Contact Investigation

____ Targeted Testing

____ Health Care Worker

____ Employment/Administrative Testing

____ Immigration Medical Exam

____ Incidental Lab Result

**RESIDENT OF CORRECTIONAL FACILITY AT TIME OF DIAGNOSIS:** ____ **No** ____**YES** **If YES,** under custody of Immigration and Customs Enforcement? _____No ____Yes

If **YES,** (*select one*) _____Federal Prison _____State Prison _____Local Jail

_____Juvenile Correctional Facility _____Other Corr. Facility

**RESIDENT OF LONG-TERM CARE FACILITY AT TIME OF DIAGNOSIS**

____No If **YES,** ____Nursing Home ____Residential Facility ____Alcohol/ Drug Treatment Facility

____**YES** ____Hospital-Based Facility ____Mental Health Residential Facility ____Other LTC Facility



**Patient's Name** _____ **State Case No.**_____

## REPORT OF VERIFIED CASE OF TUBERCULOSIS

**PRIMARY OCCUPATION WITHIN THE PAST YEAR** (*select one*)

____Health Care Worker ____Migrant/Seasonal Worker ____Not seeking Employment ( e.g. student, homemaker, disabled)
____Correctional Facility Emp. ____Other Occupation ____Retired ____Unemployed

| **Injecting Drug Use Within Past Year** | **Non-Injecting Drug Use Within Past Year** | **Excess Alcohol Use Within Past Year** |
|---|---|---|
| ____No ____Yes | ____No ____Yes | ____No ____Yes |

**ADDITIONAL TB RISK FACTORS** (*select all that apply*) ____Other *Specify* _____

____Contact of MDR-TB Patient (≤ 2 yrs) ____Incomplete LTBI Tx ____Diabetes Mellitus ____Smokes
____Contact of Infectious TB Patient (≤ 2 yrs) ____TBF-α Antagonist Tx ____End-Stage Renal Disease ____None
____Missed Contact (≤ 2 yrs) ____Post-organ Transplantation ____Immunosuppression (not HIV/AIDS)

**IMMIGRATION STATUS AT FIRST ENTRY TO THE U.S.** (*select one*)

____Not Applicable ____Immigrant Visa ____Tourist Visa ____Asylee or Parolee
* "U.S.-born" (or born abroad to a parent who was a U.S. citizen) ____Student Visa ____Family/Fiancé Visa
* Born in 1 of U.S. Teritories, U.S. Island Areas, or U.S. Outlying Areas ____Employment Visa ____Refugee ____Other Immigration Status

**DATE THERAPY STARTED (Month-Day-Year) :** ____ ____ _____

**INITIAL DRUG REGIMEN** (*select one option for each drug*)

| | No | Yes | Unk | Dosage | Date Started | | No | Yes | Unk | Dosage | Date Started |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Isoniazid | ___ | ___ | ___ | _____ | _____ | Capreomycin | ___ | ___ | ___ | _____ | _____ |
| Rifampin | ___ | ___ | ___ | _____ | _____ | Ciproflolacin | ___ | ___ | ___ | _____ | _____ |
| Pyrazinamide | ___ | ___ | ___ | _____ | _____ | Levofloxacin | ___ | ___ | ___ | _____ | _____ |
| Ethambutol | ___ | ___ | ___ | _____ | _____ | Ofloxacin | ___ | ___ | ___ | _____ | _____ |
| Streptomycin | ___ | ___ | ___ | _____ | _____ | Moxifloxacin | ___ | ___ | ___ | _____ | _____ |
| Rifabutin | ___ | ___ | ___ | _____ | _____ | Cycloserine | ___ | ___ | ___ | _____ | _____ |
| Rifapentine | ___ | ___ | ___ | _____ | _____ | PAS | ___ | ___ | ___ | _____ | _____ |
| Ethionamide | ___ | ___ | ___ | _____ | _____ | _____ | ___ | ___ | ___ | _____ | _____ |
| Amikacin | ___ | ___ | ___ | _____ | _____ | _____ | ___ | ___ | ___ | _____ | _____ |
| Kanamycin | ___ | ___ | ___ | _____ | _____ | _____ | ___ | ___ | ___ | _____ | _____ |

**COMMENTS:** _____

_____

_____

_____

**PHYSICIAN'S NAME & ADDRESS:**

_____

_____

_____

Telephone:_____ Fax:_____

**Reported by**:_____ **Date**:_____

Telephone:_____