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
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	

ADHS