1. Date Reported
   Month:   Day:   Year:

2. Date Submitted
   Month:   Day:   Year:

3. Case Numbers
   State:   Case Number:   Year Reported (YYYY):   State Code:   Locally Assigned Identification Number:
   City/County:   Case Number:   Reason:
   Linking State:   Case Number:   Linking State:   Case Number:

4. Reporting Address for Case Counting
   City:   County:   ZIP CODE:
   Within City Limits (select one):   Yes   No

5. Count Status (select one)
   Countable TB Case
   Noncountable TB Case
   Verified Case: Counted by another U.S. area (e.g., county, state)
   Verified Case: TB treatment initiated in another country
   Specified
   Verified Case: Recurrent TB within 12 months after completion of therapy

6. Date Counted
   Month:   Day:   Year:

7. Previous Diagnosis of TB Disease (select one)
   Yes   No
   If YES, enter year of previous TB disease diagnosis:

8. Date of Birth
   Month:   Day:   Year:

9. Sex at Birth (select one)
   Male   Female

10. Race (select one or more)
   American Indian or Alaska Native
   Asian:   Specify
   Black or African American
   Native Hawaiian or Other Pacific Islander:   Specify
   White

11. Ethnicity (select one)
   Hispanic or Latino
   Not Hispanic or Latino

12. Country of Birth
   “U.S.-born” (or born abroad to a parent who was a U.S. citizen) (select one)
   Yes   No
   Country of birth:   Specify

13. Month-Year Arrived in U.S.
   Month:   Year:

14. Pediatric TB Patients (<15 years old)
   Country of Birth for Primary Guardian(s):   Specify
   Guardian 1.
   Guardian 2.
   Patient lived outside U.S. for >2 months? (select one)
   Yes   No   Unknown
   If YES, list countries, specify:

15. Status at TB Diagnosis (select one)
   Alive   Dead
   If DEAD, enter date of death:
   If DEAD, was TB a cause of death? (select one)
   Yes   No   Unknown

16. Site of TB Disease (select all that apply)
   Pulmonary
   Bone and/or Joint
   Pleural
   Genitourinary
   Lymphatic: Cervical
   Meningeal
   Lymphatic: Intrathoracic
   Peritoneal
   Lymphatic: Axillary
   Other: Enter anatomic code(s) (see list):
   Site not stated
   Laryngeal

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### REPORT OF VERIFIED CASE OF TUBERCULOSIS

**17. Sputum Smear** *(select one)*
- [ ] Positive  [ ] Not Done
- [ ] Negative  [ ] Unknown

**Date Collected:**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**18. Sputum Culture** *(select one)*
- [ ] Positive  [ ] Not Done
- [ ] Negative  [ ] Unknown

**Date Collected:**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**Date Result Reported:**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**Reporting Laboratory Type** *(select one):*
- Public Health Laboratory
- Commercial Laboratory
- Other

**19. Smear/Pathology/Cytology of Tissue and Other Body Fluids** *(select one)*
- [ ] Positive  [ ] Not Done
- [ ] Negative  [ ] Unknown

**Date Collected:**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**Enter anatomic code** *(see list):*

**Type of exam** *(select all that apply):*
- Smear
- Pathology/Cytology

**20. Culture of Tissue and Other Body Fluids** *(select one)*
- [ ] Positive  [ ] Not Done
- [ ] Negative  [ ] Unknown

**Date Collected:**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**Date Result Reported:**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**Reporting Laboratory Type** *(select one):*
- Public Health Laboratory
- Commercial Laboratory
- Other

**21. Nucleic Acid Amplification Test Result** *(select one)*
- [ ] Positive  [ ] Not Done
- [ ] Negative  [ ] Unknown
- [ ] Indeterminate

**Date Collected:**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**Date Result Reported:**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**Reporting Laboratory Type** *(select one):*
- Public Health Laboratory
- Commercial Laboratory
- Other

**Enter specimen type:** Sputum
- OR
  - If not Sputum, enter anatomic code *(see list):*

**Initial Chest Radiograph and Other Chest Imaging Study**

**22A. Initial Chest Radiograph** *(select one)*
- [ ] Normal  [ ] Abnormal* *(consistent with TB)*  [ ] Not Done  [ ] Unknown  

* For ABNORMAL Initial Chest Radiograph:
  - Evidence of a cavity *(select one):*
    - Yes
    - No
    - Unknown
  - Evidence of miliary TB *(select one):*
    - Yes
    - No
    - Unknown

**22B. Initial Chest CT Scan or Other Chest Imaging Study** *(select one)*
- [ ] Normal  [ ] Abnormal* *(consistent with TB)*  [ ] Not Done  [ ] Unknown  

* For ABNORMAL Initial Chest CT Scan or Other Chest Imaging Study:
  - Evidence of a cavity *(select one):*
    - Yes
    - No
    - Unknown
  - Evidence of miliary TB *(select one):*
    - Yes
    - No
    - Unknown

**23. Tuberculin (Mantoux) Skin Test at Diagnosis** *(select one)*
- [ ] Positive  [ ] Not Done  
- [ ] Negative  [ ] Unknown

**Date Tuberculin Skin Test (TST) Placed:**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**Millimeters (mm) of induration:**

**24. Interferon Gamma Release Assay** *(select one)*
- [ ] Positive  [ ] Not Done
- [ ] Negative  [ ] Unknown
- [ ] Indeterminate

**Date Collected:**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**Test type:**

**25. Primary Reason Evaluated for TB Disease** *(select one)*
- [ ] TB Symptoms
- [ ] Abnormal Chest Radiograph *(consistent with TB)*
- [ ] Contact Investigation
- [ ] Targeted Testing
- [ ] Health Care Worker
- [ ] Employment/Administrative Testing
- [ ] Immigration Medical Exam
- [ ] Incidental Lab Result
- [ ] Unknown

---

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1st Copy

REPORT OF VERIFIED CASE OF TUBERCULOSIS  Page 2 of 3
### REPORT OF VERIFIED CASE OF TUBERCULOSIS

#### 26. HIV Status at Time of Diagnosis (select one)
- [ ] Negative
- [ ] Indeterminate
- [ ] Not Offered
- [ ] Test Done, Results Unknown
- [ ] Unknown

If POSITIVE, enter:
- [ ] State HIV/AIDS
- [ ] City/County HIV/AIDS
- [ ] Patient Number:

#### 27. Homeless Within Past Year (select one)
- [ ] No
- [ ] Yes
- [ ] Unknown

If YES,
- [ ] (select one):
  - Federal Prison
  - Local Jail
  - Other Correctional Facility
  - State Prison
  - Juvenile Correction Facility

#### 28. Resident of Correctional Facility at Time of Diagnosis (select one)
- [ ] No
- [ ] Yes
- [ ] Unknown

If YES, under custody of Immigration and Customs Enforcement?
- [ ] Yes
- [ ] Unknown

#### 29. Resident of Long-Term Care Facility at Time of Diagnosis (select one)
- [ ] No
- [ ] Yes
- [ ] Unknown

If YES,
- [ ] (select one):
  - Nursing Home
  - Residential Facility
  - Alcohol or Drug Treatment Facility
  - Other Long-Term Care Facility

#### 30. Primary Occupation Within the Past Year (select one)
- [ ] Health Care Worker
- [ ] Migrant/Seasonal Worker
- [ ] Retired
- [ ] Not Seeking Employment (e.g., student, homemaker, disabled person)
- [ ] Correctional Facility Employee
- [ ] Other Occupation
- [ ] Unemployed
- [ ] Unknown

#### 31. Injecting Drug Use Within Past Year (select one)
- [ ] No
- [ ] Yes
- [ ] Unknown

#### 32. Non-Injecting Drug Use Within Past Year (select one)
- [ ] No
- [ ] Yes
- [ ] Unknown

#### 33. Excess Alcohol Use Within Past Year (select one)
- [ ] No
- [ ] Yes
- [ ] Unknown

#### 34. Additional TB Risk Factors (select all that apply)
- [ ] Contact of MDR-TB Patient (2 years or less)
- [ ] Incomplete LTBI Therapy
- [ ] Diabetes Mellitus
- [ ] Other Specify ________________________
- [ ] Contact of Infectious TB Patient (2 years or less)
- [ ] TNF-α Antagonist Therapy
- [ ] End-Stage Renal Disease
- [ ] None
- [ ] Missed Contact (2 years or less)
- [ ] Post-organ Transplantation
- [ ] Immunosuppression (not HIV/AIDS)

#### 35. Immigration Status at First Entry to the U.S. (select one)
- [ ] Not Applicable
- [ ] “U.S.-born” (or born abroad to a parent who was a U.S. citizen)
- [ ] Other Immigration Status
- [ ] “Born in 1 of the U.S. Territories, U.S. Island Areas, or U.S. Outlying Areas
- [ ] Asylee or Parolee

#### 36. Date Therapy Started
- [ ] Month
- [ ] Day
- [ ] Year

#### 37. Initial Drug Regimen (select one option for each drug)
- Isoniazid
- Rifampin
- Pyrazinamide
- Ethambutol
- Streptomycin
- Rifabutin
- Rifapentine
- Ethionamide
- Amikacin
- Kanamycin
- Capreomycin
- Ciprofloxacin
- Levofloxacin
- Ofloxacin
- Moxifloxacin
- Cycloserine
- Para-Amino Salicylic Acid
- Other

Specify ________________________

Specify ________________________

Specify ________________________

Comments:
____________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________
**Initial Drug Susceptibility Report**

(Follow Up Report – 1)

<table>
<thead>
<tr>
<th>Year Counted</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>City/County</td>
<td>Case Number</td>
</tr>
</tbody>
</table>

Submit this report for all culture-positive cases.

38. Genotyping Accession Number

Isolate submitted for genotyping (select one):  
- [ ] No  
- [ ] Yes  

If YES, genotyping accession number for episode:

<table>
<thead>
<tr>
<th>Genotyping Accession Number</th>
</tr>
</thead>
</table>

39. Initial Drug Susceptibility Testing

Was drug susceptibility testing done? (select one):

- [ ] No  
- [ ] Yes  
- [ ] Unknown  

If NO or UNKNOWN, do not complete the rest of Follow Up Report – 1

If YES, enter date FIRST specimen collected on which initial drug susceptibility testing was done:

- [ ] Month  
- [ ] Day  
- [ ] Year

Enter specimen type:

- [ ] Sputum  
- [ ] OR  

If not Sputum, enter anatomic code (see list):

40. Initial Drug Susceptibility Results (select one option for each drug)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Resistant</th>
<th>Susceptible</th>
<th>Not Done</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isoniazid</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Rifampin</td>
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<tr>
<td>Pyrazinamide</td>
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<tr>
<td>Ethionamide</td>
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<tr>
<td>Para-Amino Salicylic Acid</td>
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<tr>
<td>Other</td>
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</table>

Specify:

Comments:

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### Case Completion Report

<table>
<thead>
<tr>
<th>Year Counted</th>
<th>State</th>
<th>Case Number</th>
</tr>
</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>City/County</th>
<th>Case Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Submit this report for all cases in which the patient was alive at diagnosis.

#### 41. Sputum Culture Conversion Documented (select one)
- [ ] No
- [ ] Yes
- [ ] Unknown

If YES, enter date specimen collected for FIRST consistently negative sputum culture:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

If NO, enter reason for not documenting sputum culture conversion (select one):

- [ ] No Follow-up
- [ ] Sputum Despite Induction
- [ ] Patient Refused
- [ ] Patient Lost to Follow-Up
- [ ] No Follow-up Sputum and No Induction
- [ ] Other Specify
- [ ] Died
- [ ] Unknown

#### 42. Moved

- [ ] No
- [ ] Yes

Did the patient move during TB therapy? (select one)

If YES, moved to where (select all that apply):

- [ ] In state, out of jurisdiction (enter city/county) Specify ____________________________________________
- [ ] Out of state (enter state) Specify ____________________________________________
- [ ] Out of the U.S. (enter country) Specify ____________________________________________

If moved out of the U.S., transnational referral? (select one)

- [ ] No
- [ ] Yes

#### 43. Date Therapy Stopped

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

#### 44. Reason Therapy Stopped or Never Started (select one)

- [ ] Completed Therapy
- [ ] Not TB
- [ ] Lost
- [ ] Died
- [ ] Related to TB disease
- [ ] Unrelated to TB disease
- [ ] Uncooperative or Refused
- [ ] Other
- [ ] Related to TB therapy
- [ ] Unknown
- [ ] Adverse Treatment Event
- [ ] Unknown

If DIED, indicate cause of death (select one):

- [ ] Clinically Indicated – other reasons

#### 45. Reason Therapy Extended >12 months (select all that apply)

- [ ] Rifampin Resistance
- [ ] Non-adherence
- [ ] Clinically Indicated – other reasons
- [ ] Adverse Drug Reaction
- [ ] Failure
- [ ] Other Specify ____________________________________________

#### 46. Type of Outpatient Health Care Provider (select all that apply)

- [ ] Local/State Health Department (HD)
- [ ] IHS, Tribal HD, or Tribal Corporation
- [ ] Inpatient Care Only
- [ ] Unknown
- [ ] Private Outpatient
- [ ] Institutional/Correctional
- [ ] Other

Comments:

_____________________________________________________________________________________________________________________________________________________________________________
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47. Directly Observed Therapy (DOT) (select one)
- No, Totally Self-Administered
- Yes, Totally Directly Observed
- Yes, Both Directly Observed and Self-Administered
- Unknown

Number of weeks of directly observed therapy (DOT)

48. Final Drug Susceptibility Testing
Was follow-up drug susceptibility testing done? (select one)
- No
- Yes
- Unknown

If NO or UNKNOWN, do not complete the rest of Follow Up Report – 2

If YES, enter date FINAL specimen collected on which drug susceptibility testing was done:

Enter specimen type:
- Sputum

OR
If not Sputum, enter anatomic code (see list):

49. Final Drug Susceptibility Results (select one option for each drug)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Resistant</th>
<th>Susceptible</th>
<th>Not Done</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isoniazid</td>
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Comments:

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