REPORT OF TUBERCULOSIS

State Form 14058 (R8 / 10-10)

INDIANA STATE DEPARTMENT OF HEALTH

2 North Meridian Street, Section 6-D
Indianapolis, IN 46204
(317) 233-7434

TB Law: Every suspected and verified case of tuberculosis disease must be reported to the local health officer within 72 hours (from probable diagnosis) in accordance with 410 IAC 1-2.3

1. Patient Name *(Last, First, MI)*

_____

2. Address _____

_____

City_____ Within city limits ☐ Yes ☐ No

Telephone (_____)_____

County_____ ZIP Code_____

3. Date of birth ____-_____-_____ **4. At time of report** ☐ Alive ☐ Dead

5. Age_____ **6. Sex** ☐ Male ☐ Female

7. Primary occupation within past 12 months (*select one)*

☐ Health Care Worker ☐ Migrant/Seasonal Worker
☐ Correctional Facility Worker ☐ Retired ☐ Unemployed
☐ Not Seeking Employment (e.g., student, homemaker, disabled person)
☐ Other Occupation (*specify*) _____
Place of Employment/School _____

8. Race (*check all that apply)*

☐ White ☐ American Indian or Alaska Native ☐ Asian *(specify)* _____

☐ Black or African-American ☐ Native Hawaiian or other Pacific Islander *(specify)* _____

9. Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

10. Born in the United States ☐ Yes ☐ No

If "No," country of birth_____ Alien Number _____

Immigration Status at first entry to the U.S. ☐ Immigrant ☐ Refugee ☐ Other

Date arrived in the U.S. *(month, year)* _____--_____

FOR LOCAL HEALTH DEPARTMENT USE ONLY

Date local health department notified of TB Suspect/TB Case _____

Reported by_____ Telephone (____)_____

FOR ALL NON LOCAL HEALTH DEPARTMENT USE ONLY

Reported by:_____

Agency:_____

Telephone (_____)_____ Fax (____)_____

Attending Physician:_____

Telephone (_____)_____ Fax (____)_____

11. Pediatric TB Patients (<15 years old)

Country of Birth for Primary Guardian(s) *(specify)*

Guardian 1 _____

Guardian 2 _____

Did patient live outside U.S. for >2 months? ☐ Yes ☐ No

If yes, list countries _____

12. TB Skin Test/Interferon Gamma Release Assay (IGRA) for MTB at diagnosis

Mantoux test ☐ Positive ☐ Negative ☐ Not Done

Date given *(month, day, year)* _____ Date read *(month, day, year)* _____ Results _____mm

IGRA Test Type *(select one)* ☐ QFT-Gold ☐ QFT-IN Tube ☐ T Spot

☐ Positive ☐ Negative ☐ Indeterminate ☐ Borderline ☐ Not Done

IGRA Quantitative Result _____ **Date collected** *(month, day, year)* _____

13. Primary Reason Evaluated for TB Disease *(select one)*

- ☐ Contact to TB case Name of case _____
- ☐ Contact Investigation
- ☐ TB Symptoms
- ☐ Abnormal Chest Radiograph (consistent with TB)
- ☐ Targeted Testing
- ☐ Health Care Worker
- ☐ Employment/Administrative Testing
- ☐ Immigration Medical Exam
- ☐ Incidental Lab Result
- ☐ Other *(specify)* _____

14. Additional Risk Factors *(select all that apply)*

- ☐ Contact of MDR-TB Patient (2 years or less)
- ☐ Contact of Infectious Patient (2 years or less)
- ☐ Missed Contact (2 years or less)
- ☐ Incomplete LTBI Therapy
- ☐ TNF-α Antagonist Therapy
- ☐ Immunosuppression (not HIV/AIDS)
- ☐ Diabetes Mellitus
- ☐ End-Stage Renal Disease
- ☐ Post-organ Transplantation
- ☐ Other *(specify)* _____

15. Has the patient been homeless within the past year? ☐ Yes ☐ No

If yes, Facility Name _____

16. Resident of long-term care facility at time of diagnosis? ☐ Yes ☐ No

If yes, *(select one)* **Facility Name** _____

- ☐ Nursing Home ☐ Residential Facility ☐ Alcohol or Drug Treatment Facility
- ☐ Hospital-Based Facility ☐ Mental Health Residential Facility
- ☐ Other Long-Term Care Facility

17. Resident of correctional facility at time of diagnosis? ☐ Yes ☐ No

If yes, *(select one)* **Facility Name** _____

- ☐ Local Jail ☐ State Prison ☐ Federal Prison ☐ Juvenile Correctional Facility
- ☐ Other Correctional Facility

18. Any history of incarceration? ☐ Yes ☐ No

Location/date of most recent incarceration _____

19. Alcohol and Drug Use (within the past year)?

Excess alcohol intake? ☐ Yes ☐ No

Injection drug use? ☐ Yes ☐ No

Non-injecting drug use? ☐ Yes ☐ No

20. HIV Status at Time of Diagnosis *(select one)*

Date of HIV Test *(month, day, year)* _____

- ☐ Negative
- ☐ Positive
- ☐ Indeterminate
- ☐ Pending
- ☐ Refused
- ☐ Not Offered

21. Previous diagnosis of active TB? ☐ Yes ☐ No

If yes, year of diagnosis _____

22. Inpatient (hospital) during TB workup? ☐ Yes ☐ No

If yes, name of Hospital _____

23. Site of Disease *(select all that apply)*

- ☐ Pulmonary
- ☐ Pleural
- ☐ Lymphatic: Cervical
- ☐ Lymphatic: Intrathoracic
- ☐ Lymphatic: Axillary
- ☐ Lymphatic: Other
- ☐ Lymphatic: Unknown
- ☐ Laryngeal
- ☐ Bone and/or Joint
- ☐ Genitourinary
- ☐ Meningeal
- ☐ Peritoneal
- ☐ Other _____

24. Clinical Symptoms *(select all that apply)*

- ☐ Prolonged productive cough
- ☐ Hemoptysis
- ☐ Chest pain
- ☐ Night sweats
- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Other _____
- ☐ Fatigue
- ☐ Loss of appetite

Date of onset of symptoms *(month, day, year)* _____

Patient Name _____

25. Laboratory Specimens

Laboratory performing testing

☐ ISDH Lab

☐ Other Lab *(specify)* _____

26. Sputum Smear *(select one)*

☐ Positive ☐ Negative ☐ Not Done

Date of collection *(month, day, year)* _____

27. Sputum Culture *(select one)*

☐ Positive ☐ Negative ☐ Not Done

Date of collection *(month, day, year)* _____

28. Smear/Pathology/Cytology of Tissue and Other Body Fluids *(select one)*

☐ Positive ☐ Negative ☐ Not Done

Date of collection *(month, day, year)* _____

Type of Exam *(select all that apply)* ☐ Smear ☐ Pathology/Cytology

Specify Type of Specimen _____

29. Culture of Tissue and Other Body Fluids *(select one)*

☐ Positive ☐ Negative ☐ Not Done

Date of collection *(month, day, year)* _____

Specify Type of Specimen _____

30. Nucleic Acid Amplification Test Results *(select one)*

☐ Positive ☐ Negative ☐ Indeterminate ☐ Not Done

Date of collection *(month, day, year)* _____

Test Type ☐ MTD ☐ PCR Testing

Specimen Type ☐ Sputum

If not sputum, specify type of specimen _____

31. Radiology/Other Chest Imaging Study

Initial Chest X-Ray ☐ Normal ☐ Abnormal ☐ Not Done

If abnormal, evidence of cavity? ☐ Yes ☐ No

If abnormal, evidence of military TB? ☐ Yes ☐ No

Date of Chest X-Ray *(month, day, year)* _____

Previous Chest X-Ray Date (if known) *(month, day, year)* _____

Initial Chest CT Scan or Other Imaging Study

☐ Normal ☐ Abnormal ☐ Not Done

If abnormal, evidence of cavity? ☐ Yes ☐ No

If abnormal, evidence of military TB? ☐ Yes ☐ No

Date of CT/Other Imaging *(month, day, year)* _____

Previous CT/Other Imaging Date (if known) *(month, day, year)* _____

32. Initial Drug Regimen

☐ Isoniazid Dose _____

☐ Rifampin Dose _____

☐ Pyrazinamide Dose _____

☐ Ethambutol Dose _____

☐ Vitamin B6 Dose _____

☐ Other *(specify)* _____

33. Patient's Current Weight _____ pounds / 2.2 = _____ Kg

34. Date Therapy Started *(month, day, year)* _____

35. Requesting drugs through ISDH? ☐ Yes ☐ No
(please submit prescriptions and drug request form)

36. Infectious Period

Beginning Date (3 months prior to start of symptoms) *(month, day, year)*_____

Ending Date *(month, day, year)*_____

Notes/Comments

Patient Name _____