NEW JERSEY TUBERCULOSIS CASE, SUSPECT AND STATUS REPORT

TB-70

SHADED AREAS ARE FOR STATE USE ONLY; LEAVE BLANK.

Type of Report: ☐ Initial ☐ Recurrence ☐ Current Status

Patient's Name (Last, First, MI)

4. Street Address: (Check if New ☐) Within City Limits: ☐ Yes ☐ No

Telephone:

County:

City: **State:** **Zip Code:**

Municipal Code: ☐☐☐☐

1. Date Reported *(mm/dd/yyyy)*

2. Date Submitted
Month *Day* *Year*
☐☐ ☐☐ ☐☐☐☐

3. CASE NUMBERS:

	Year Reported	State	Identification Number
STATE CASE NO.:			
LINKING CASE NO.:			
LINKING CASE NO.:			

REASON:

5. Count Status: *(select one)*
☐ Count as a TB case

Noncountable TB Case
☐ Suspect
☐ Counted by another US area
☐ TB treatment initiated in another country
Specify: _____
☐ Recurrent TB within 12 months after completion of therapy

8. Date of Birth:

9. Sex at Birth
☐ Male
☐ Female

10. Race: *(select all that apply)*
☐ American Indian or Alaska Native
☐ Asian: *(specify)*
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander:
Specify _____
☐ White

6. Date Counted:
Month *Day* *Year*
☐☐ ☐☐ ☐☐☐☐

11. Ethnicity:
☐ 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: _____

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

13. Month-Year Arrived in US:
-

14. Pediatric TB Patients (<15 years old):
Country of birth for primary Guardian(s): *(specify)*
Guardian 1: _____
Guardian 2: _____
Patient lived outside the U.S. for >2 months?
☐ 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 the cause of Death?
☐ Yes ☐ No ☐ Unknown

16. Site of TB Disease *(select all that apply)*
☐ Pulmonary
☐ Pleural
☐ Lymphatic: Cervical
☐ Lymphatic: Intrathoracic
☐ Lymphatic: Axillary
☐ Lymphatic: Other
☐ Lymphatic: Unknown
☐ Bone and/or Joint
☐ Genitourinary
☐ Meningeal
☐ Peritoneal
☐ Site not stated
☐ Laryngeal
☐ Other (Specify): _____

(state use only)
1 ☐☐
2 ☐☐
3 ☐☐

NEW JERSEY TUBERCULOSIS CASE, SUSPECT AND STATUS REPORT

(Continued)

Patient Name	Case Number	Date

17. Sputum Smear: *(select one)*
☐ Positive ☐ Not Done Date Collected:
☐ Negative ☐ Unknown

17a. Sputum Smear: *(select one)*
☐ Positive ☐ Not Done Date Collected:
☐ Negative ☐ Unknown

18. Sputum Culture: *(select one)*
☐ Positive ☐ Not Done Date Collected:
☐ Negative ☐ Unknown Date Reported:
Laboratory *(specify)*:

18a. Sputum Culture: *(select one)*
☐ Positive ☐ Not Done Date Collected:
☐ Negative ☐ Unknown Date Reported:
Laboratory *(specify)*:

19. Smear/Pathology/Cytology of Tissue and Other Body Fluids: *(select one)*
☐ Positive ☐ Not Done Date Collected:
☐ Negative ☐ Unknown
Type of Exam *(select all that apply)*:
☐ Smear ☐ Pathology/Cytology
Source *(specify)*:

19. Smear/Pathology/Cytology of Tissue and Other Body Fluids: *(select one)*
☐ Positive ☐ Not Done Date Collected:
☐ Negative ☐ Unknown
Type of Exam *(select all that apply)*:
☐ Smear ☐ Pathology/Cytology
Source *(specify)*:

Anatomic Code ☐☐

20. Culture of Tissue and Other Body Fluids: *(select one)*
☐ Positive ☐ Not Done Date Collected:
☐ Negative ☐ Unknown Date Reported:
Source *(specify)*:
Lab:

20a. Culture of Tissue and Other Body Fluids: *(select one):*
☐ Positive ☐ Not Done Date Collected:
☐ Negative ☐ Unknown Date Reported:
Source *(specify)*:
Lab:

Anatomic Code ☐☐

21. Nucleic Acid Amplification Test Result: *(select one)*
☐ Positive ☐ Not Done Date Collected:
☐ Negative ☐ Unknown Date Result Reported:
☐ Indeterminate
Enter specimen type: ☐ Sputum **OR** if not sputum, specify:
Source *(specify)*:
Laboratory *(specify)*:

Anatomic Code ☐☐

22. Chest Radiograph and Other Chest Imaging Study

22A. Initial Chest Radiograph: Date: *(select one)* ☐ Normal ☐ Abnormal * ☐ Not Done ☐ Unknown
* For ABNORMAL Initial Chest Radiograph:
Evidence of a cavity? *(select one)* ☐ Yes ☐ No ☐ Unknown
Consistent with TB? *(select one)* ☐ Yes ☐ No ☐ Unknown
Evidence of miliary TB? *(select one)* ☐ Yes ☐ No ☐ Unknown

22B. Initial Chest CT Scan or Other Chest Imaging Study: Date: *(select one)* ☐ Normal ☐ Abnormal * ☐ Not Done ☐ Unknown
* For ABNORMAL Initial Study:
Evidence of a cavity? *(select one)* ☐ Yes ☐ No ☐ Unknown
Consistent with TB? *(select one)* ☐ Yes ☐ No ☐ Unknown
Evidence of miliary TB? *(select one)* ☐ Yes ☐ No ☐ Unknown

22C. Follow up Chest Radiograph, CT Scan or Other Chest Imaging Study: Date: ☐ Chest *(select one)* ☐ Improved ☐ Worsening ☐ Stable
☐ CT Scan ☐ Other *(specify)*:

23.Tuberculin (Mantoux) Skin Test at Diagnosis: *(select one)*
☐ Positive ☐ Not Done
☐ Negative ☐ Unknown
Date Test Placed: _____ Millimeters Induration:

24. Interferon Gamma Release Assay for Mycobacterium Tuberculosis at Diagnosis: *(select one)*
Date Collected:
☐ Positive ☐ Not Done
☐ Negative ☐ Unknown
☐ Indeterminate Test Type *(specify)*:

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

NEW JERSEY TUBERCULOSIS CASE, SUSPECT AND STATUS REPORT

(Continued)

Patient Name	Case Number	Date

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

☐ Negative ☐ Indeterminate ☐ Not Offered ☐ Unknown
☐ Positive ☐ Refused ☐ Test Done Results Unknown

State Patient Number:

☐☐☐☐☐☐☐☐☐☐

27. Homeless Within The Past Year? *(select one)*

☐ No
☐ Yes
☐ Unknown

28. Resident of Correctional Facility at Time of Diagnosis? *(select one)*

☐ No ☐ Yes ☐ Unknown

If Yes: *(select one)*

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

If Yes, under the custody of Immigration and Customs Enforcement?

☐ No ☐ Yes

Name of Facility:

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 ☐ Unknown
☐ Hospital-based Facility ☐ Mental Health Residential Facility ☐ Other Long Term Care Facility

Name of 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)
☐ Correctional Facility Employee ☐ Unemployed ☐ Unknown ☐ Other *(specify)*:

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 Treatment ☐ Diabetes Mellitus ☐ Other (*Specify)*
☐ Contact of Infectious TB Patient (2 years or less) ☐ TNF-a 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)*

☐ Immigrant Visa ☐ Tourist Visa ☐ Asylee or Parolee
☐ Student Visa ☐ Family Fiancé Visa ☐ Other Immigration Status
☐ Not Applicable ☐ Employment Visa ☐ Refugee ☐ Unknown

* U.S. Born (or born abroad to a parent that was a U.S. Citizen)
* Born in one of the U.S. Territories, U.S. Island Areas or U.S. Outlying Areas

36. Initial Therapy Started

mm/dd/yyyy

_____

36a. Current Therapy *

mm/dd/yyyy

37. Initial Drug Regimen ☐

	mg
☐ Isoniazid	_____
☐ Rifampin	_____
☐ Pyrazinamide	_____
☐ Ethambutol	_____
☐ Streptomycin	_____
☐ Rifabutin	_____
☐ Rifapentine	_____

37A. Current Drug Regimen ☐

	mg		mg		mg
☐ Ethionamide	_____	☐ Amikacin	_____	☐ Kanamycin	_____
☐ Capreomycin	_____	☐ Ciprofloxacin	_____	☐ Levofloxacin	_____
☐ Ofloxacin	_____	☐ Moxifloxacin	_____	☐ Cycloserine	_____
☐ Para-Amino Salicylic Acid	_____	☐ Other _____	_____ mg	☐ Other _____	_____ mg

Patient's Weight: _____ lbs.
_____ kg.

***Please document current drug regimen changes and discontinued medications**

NEW JERSEY TUBERCULOSIS CASE, SUSPECT AND STATUS REPORT

(Continued)

Patient Name	Case Number	Date

UD7. Hospitalization

Hospital Name: Telephone:

Medical Record #: Admission Date: Discharge Date:

I. Diagnosing Physician

Name: Telephone:

City: State:

II. Other Physician

Name: Telephone:

City: State:

III. Case Manager

Name: Telephone:

UD8. Supervision is *NOW* being provided by

☐ Health Dept. ☐ Private/Hospital/Hosp. Clinic/Institution ☐ Both HD and Private

Name: Telephone:

City: State:

Report Prepared By

Name: Telephone: Date:

Remarks:

Signature: *(not legal unless signed)*

NEW JERSEY TUBERCULOSIS CASE, SUSPECT AND STATUS REPORT

(Continued)

Patient Name	Case Number	Date

Follow up 1

38. Genotyping Accession Number

Isolate submitted for genotyping? ☐ Yes ☐ No

If YES, genotyping Accession Number for episode: ☐☐☐☐☐☐☐☐☐☐☐☐☐

39. Initial Drug Susceptibility Testing:

Was drug susceptibility testing done? *(select one)*

☐ No ☐ Yes ☐ Unknown

Date first isolate collected for which drug susceptibility was done:

mm/dd/yyyy

Enter specimen type:

☐ Sputum **OR** if not sputum:

Specify Source:

39a. Other Drug Susceptibility Testing:

Was drug susceptibility testing done? *(select one)*

☐ No ☐ Yes ☐ Unknown

Date first isolate collected for which drug susceptibility was done:

mm/dd/yyyy

Enter specimen type:

☐ Sputum **OR** if not sputum:

Specify Source:

Anatomic Code

☐☐

40. Drug Susceptibility Results *(select one)*

☐ Initial ☐ Other

(Select one option for each drug checked)

	Resistant	Sensitive	Not Done	Unknown
☐ Isoniazid	☐	☐	☐	☐
☐ Rifampin	☐	☐	☐	☐
☐ Pyrazinamide	☐	☐	☐	☐
☐ Ethambutol	☐	☐	☐	☐
☐ Streptomycin	☐	☐	☐	☐
☐ Rifabutin	☐	☐	☐	☐
☐ Rifapentine	☐	☐	☐	☐
☐ Ethionamide	☐	☐	☐	☐
☐ Amikacin	☐	☐	☐	☐
☐ Kanamycin	☐	☐	☐	☐

	Resistant	Sensitive	Not Done	Unknown
☐ Capreomycin	☐	☐	☐	☐
☐ Ciprofloxacin	☐	☐	☐	☐
☐ Levofloxacin	☐	☐	☐	☐
☐ Ofloxacin	☐	☐	☐	☐
☐ Moxifloxacin	☐	☐	☐	☐
☐ Other Quinolones	☐	☐	☐	☐
☐ Cycloserine	☐	☐	☐	☐
☐ PAS	☐	☐	☐	☐
☐ Gatifloxacin	☐	☐	☐	☐
☐ Other drug Specify:	☐	☐	☐	☐
☐ Other drug Specify:	☐	☐	☐	☐

Specify Lab:

Follow up 2

41.Sputum Culture Conversion Documented *(select one)*

☐ No ☐ Yes ☐ Unknown

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

mm/dd/yyyy

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

☐ Clinically Improved ☐ Patient refused ☐ Patient lost to follow up

☐ No follow-up sputum collected ☐ Other Specify:

☐ Died ☐ Unknown

42. Moved *(Must Include Address)*

Did the patient move during TB therapy: ☐ No ☐ Yes

New Address:

Phone #:

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

☐ In state, out of jurisdiction (enter city/county) Specify _____ Specify

☐ Out of state (enter state) Specify _____ Specify

☐ Out of the U.S. (enter country) Specify _____ Specify

If moved out of the U.S., transnational referral? (select one) ☐ No ☐ Yes

43. Date Therapy Stopped:

mm/dd/yyyy

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

☐ Completed therapy ☐ Not TB

☐ Lost ☐ **Died**

☐ Uncooperative or refused ☐ Other

☐ Adverse treatment event ☐ Unknown

If Died, Indicate Cause of Death: *(select one)*

☐ Related to TB disease ☐ Unrelated to TB disease

☐ Related to TB therapy ☐ Unknown

NEW JERSEY TUBERCULOSIS CASE, SUSPECT AND STATUS REPORT

(Continued)

Patient Name	Case Number	Date

Follow up 2 (Continued)

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 ☐ IHS, Tribal HD, or Tribal Corp. ☐ Inpatient care only ☐ Unknown
☐ Private Outpatient ☐ Institutional/Correctional ☐ Other

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. Follow-up Drug Susceptibility Testing:

Was follow-up drug susceptibility testing done? ☐ No ☐ Yes ☐ Unknown

If **No or Unknown**, do not complete the rest of the form.

If Yes: Enter date last isolate collected for which drug susceptibility testing was done:

☐☐

mm/dd/yyyy

Enter specimen type: ☐ Sputum **OR** if not sputum, specify:

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

	Resistant	Sensitive	Not Done	Unknown
☐ Isoniazid	☐	☐	☐	☐
☐ Rifampin	☐	☐	☐	☐
☐ Pyrazinamide	☐	☐	☐	☐
☐ Ethambutol	☐	☐	☐	☐
☐ Streptomycin	☐	☐	☐	☐
☐ Rifabutin	☐	☐	☐	☐
☐ Rifapentine	☐	☐	☐	☐
☐ Ethionamide	☐	☐	☐	☐
☐ Amikacin	☐	☐	☐	☐
☐ Kanamycin	☐	☐	☐	☐

	Resistant	Sensitive	Not Done	Unknown
☐ Capreomycin	☐	☐	☐	☐
☐ Ciprofloxacin	☐	☐	☐	☐
☐ Levofloxacin	☐	☐	☐	☐
☐ Ofloxacin	☐	☐	☐	☐
☐ Moxifloxacin	☐	☐	☐	☐
☐ Other Quinolones	☐	☐	☐	☐
☐ Cycloserine	☐	☐	☐	☐
☐ PAS	☐	☐	☐	☐
☐ Gatifloxacin	☐	☐	☐	☐
☐ Other drug Specify:	☐	☐	☐	☐
☐ Other drug Specify:	☐	☐	☐	☐

Lab:

Report prepared by

Name: Telephone: Date:

Remarks:

Signature: *(not legal unless signed)*