

TUBERCULOSIS SURVEILLANCE AND CASE MANAGEMENT REPORT



Colorado Department of Public Health and Environment
Tuberculosis Program
4300 Cherry Creek Drive South
DCEED-TB-A3
Denver, Colorado 80246-1530
(303) 692-2638 phone (303) 691-7749 fax

DEMOGRAPHICS LOCATING INFORMATION

Last Name _____ **First Name** _____ **MI** _____

Date of Birth _____ / _____ / _____

Gender: Male Female

Race: American Indian/Alaskan
 Asian
 Black/African American
 Native Hawaiian/Other Pacific Is.
 White
 Unknown

Ethnicity: Not Hispanic/Latino
 Hispanic/Latino

Country of Birth: United States
 Mexico

 Specify other

Date Arrived in US: _____ / _____

 Month/Year

Occupation:

New health care worker
 Current health care worker (HAS patient contact)
 Current health care worker (NO patient contact)
 Corrections employee
 Migrant farm worker Unknown
 Unemployed past 24 months Other

Employer _____

 Specify other

Current Home Address (Number & Street Name) _____ **Apt #** _____

City _____ **State** _____ **Zip Code** _____ **County** _____

Other Address (Number & Street Name) _____ **Specify Type** _____

City _____ **State** _____ **Zip Code** _____ **County** _____

() _____ () _____
Home Phone Number **Other Phone Number** **Specify Type**

() _____
Work Phone Number

TUBERCULIN SKIN TEST (TST)

Current TST Type: Mantoux- Tubersol Mantoux- Aplisol
 Mantoux- Unspecified Not done Unknown

Reason For Test: Administrative Class B TB Notification
 Contact investigation Employment
 Immigration status change Known active
 Source case investigation

Suspect case Symptomatic
 Targeted testing- individual
 Targeted testing- pregnancy
 Targeted testing- specific project
 Transfer case/suspect Unknown

Name of Clinic/Local Health Agency Placing TST _____

Current TST _____ / _____ / _____ mm **Previous TST** _____ / _____ / _____ mm

Date Given _____ **Date Read** _____ **Reading** _____ **Date** _____ **Reading** _____

Current TST Result Negative Positive (please select criteria below) Not read

TST positive at 5 mm or greater

HIV positive person
 Recent, close contact to active TB
 Has fibrotic lesions on CXR consistent with previous TB disease
 Patients with organ transplants or other immunosuppressed patients
 TB suspects

TST positive at 10 mm or greater

Recent arrival from a country with a high prevalence of TB
 Injection drug user
 Resident of high risk congregate setting
 Employee of high risk congregate setting
 Mycobacteriology laboratory personnel
 High risk clinical conditions
 Child < 4 years old, or child or adolescent exposed to adult in high risk category

TST positive at 15 mm or greater

No known risk factors for TB

QuantIFERON (QFT) X-RAY FINDINGS

Collection Date _____ / _____ / _____ **Testing Laboratory** _____

QFT Results Positive Indeterminate
 Negative Unknown

Current CXR Results: _____ / _____ / _____ **Date Taken** _____

Cavitation Non-TB abnormality
 Infiltrates Normal
 Pleural disease Other _____

Previous CXR Results: _____ / _____ / _____ **Date Taken** _____

Cavitation Non-TB abnormality
 Infiltrates Normal
 Pleural disease Other _____

Patient Last Name _____ First Name _____ MI _____ Date of Birth _____ / ____ / ____

MEDICAL HISTORY

Symptoms: <input type="checkbox"/> None <input type="checkbox"/> Cough > 3 wks <input type="checkbox"/> Productive cough <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Chest pain <input type="checkbox"/> Weight loss <input type="checkbox"/> Night sweats <input type="checkbox"/> Urinary <input type="checkbox"/> Fever <input type="checkbox"/> Other (specify) _____	Symptom Length: _____ _____ _____ _____ _____ _____ _____ _____	Alcohol <input type="checkbox"/> Yes Abuse: <input type="checkbox"/> No <input type="checkbox"/> Unknown Drug <input type="checkbox"/> Injecting Abuse: <input type="checkbox"/> Noninjecting <input type="checkbox"/> No <input type="checkbox"/> Unknown Previous <input type="checkbox"/> Yes TB <input type="checkbox"/> No Diagnosis <input type="checkbox"/> Unknown	HIV <input type="checkbox"/> Yes Test: <input type="checkbox"/> No <input type="checkbox"/> Unknown HIV <input type="checkbox"/> Positive Result: <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown _____ _____ _____ HIV Test Date _____ / ____ / ____	Allergies: _____ Medications: _____ _____ _____ _____ _____
---	--	--	---	--

RISKS AND SPECIAL CONDITIONS

Exposure <input type="checkbox"/> None Risks: <input type="checkbox"/> Homeless <input type="checkbox"/> Resident of correctional facility (if Yes check one) <input type="checkbox"/> Federal prison <input type="checkbox"/> State prison <input type="checkbox"/> Local jail <input type="checkbox"/> Juvenile <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Resident of long term care facility (if Yes check one) <input type="checkbox"/> Nursing home <input type="checkbox"/> Hospital <input type="checkbox"/> Residential <input type="checkbox"/> Mental health <input type="checkbox"/> Alcohol/drug treatment <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown <input type="checkbox"/> TST conversion in last 2 years	Medical <input type="checkbox"/> None Risks: <input type="checkbox"/> Heart disease <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Weight loss > 10 lbs <input type="checkbox"/> Gastrectomy <input type="checkbox"/> Jejunioleal bypass Special <input type="checkbox"/> Pregnant EDC _____ / ____ / ____ Conditions: <input type="checkbox"/> Postpartum breast feeding <input type="checkbox"/> Other special conditions _____	<input type="checkbox"/> Silicosis <input type="checkbox"/> Immunosuppressive therapy <input type="checkbox"/> Cancer <input type="checkbox"/> Hepatitis <input type="checkbox"/> Renal failure
---	---	--	---

TREATMENT

<input type="checkbox"/> Current treatment _____ / ____ / ____ <input type="checkbox"/> Past treatment _____ / ____ / ____	Therapy Start Date _____ / ____ / ____ Therapy End Date _____ / ____ / ____		
Isoniazid _____ mg Rifampin _____ mg Pyrazinamide _____ mg Ethambutol _____ mg	Other _____ mg Other _____ mg Other _____ mg	Reason <input type="checkbox"/> Died Stopped: <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Moved <input type="checkbox"/> Adverse reaction	<input type="checkbox"/> Course completed <input type="checkbox"/> Uncooperative/refused <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____

CASE COMPLETION

Final Case Status: Closed Died
 Moved away Not determined
 Lost contact

If Moved New Address (Number & Street Name)

City _____ **State** _____ **Zip Code** _____

SOURCE INFORMATION

If the person is a contact to an active case complete information on the source case

Last Name _____ **First Name** _____

Relation to Source _____ **Exposure Dates** _____ / ____ / ____ to _____ / ____ / ____

PROVIDER INFORMATION

_____ Local Health Agency (LHA)	_____ PCP/Clinic Name	() _____ PCP Phone Number	
() _____ LHA Phone Number	() _____ LHA Fax Number	() _____ PCP Fax Number	
_____ Nurse	_____ PCP City	_____ PCP State	_____ PCP Zip Code

COMMENTS

Person completing form _____ / ____ / ____
Date