We use the tuberculosis (TB) case report form to collect surveillance data on TB suspects and cases. We report the data to CDC, and analyze it locally.

These instructions tell you how to fill out the report form. They aren’t a substitute for expert clinical opinion or CDC guidelines on medical TB management. Please contact us with questions on TB diagnosis and case management.

I. Submitting the TB Case Report Form

A report should be made whenever:

1. A patient is started on multidrug therapy for TB
2. A patient has a positive nucleic acid amplification test (NAAT, MTD, Xpert MTB/RIF) or positive culture test for M. tuberculosis complex
3. A patient has a pathology report consistent with tuberculosis

When to submit:

You need to submit the case report form three times:

Initial Report:
Send within one week after you are notified of a suspect or confirmed case.
Enter the initial submit date in the “Report and Date” section (top right hand corner).

Verification Update:
Send an update when TB disease status is determined - usually after culture results are received or after two months treatment for clinical cases. Enter the verification submit date in the “Report and Date” section.
If the case is lab-confirmed at initial report, you do not need to send the form in twice. Send one copy of the form and enter the same date for the initial and verification date.

Closure Report:
Send a final update when the case is closed. Enter the closure date in the “Report and Date” section.
If the case is closed at the same time as the verification update (verified as NOT TB) you do not need to send the form twice. Send one copy of the form and enter the same date for the verification and closure date.

Submit to:
Fax: (971) 673-0178 (preferred) -or- Mail: TB Control Program
Send attention: TB Program Oregon Health Authority
800 NE Oregon Street, Suite 1105 Portland, OR 97232

II. How to fill out the TB case report form

The TB case report form has 9 sections: Administrative (header information), Case Identification, Demographics, Basis of Diagnosis, Bacteriology, TB Risks, Treatment, Verification, and Closure. The data elements we collect in each section are outlined below.
Section 1: ADMINISTRATIVE

<table>
<thead>
<tr>
<th>Tuberculosis Disease</th>
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</thead>
<tbody>
<tr>
<td>Local health department:</td>
</tr>
<tr>
<td>Case manager:</td>
</tr>
<tr>
<td>Treating physician(s):</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
</tbody>
</table>

**Local Health Department**
Enter the local health department in which the case lives. Contact us if you need help determining jurisdiction.

**Case Manager**
Enter the nurse case manager’s name.

**Treating Physician**
Enter the name and phone number of the physician(s) treating the case.

**Report and Date**
Enter the date the case report form is sent to the State (for initial, verification, and closure submissions).

Section 2: CASE IDENTIFICATION

<table>
<thead>
<tr>
<th>Case Identification</th>
</tr>
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<tbody>
<tr>
<td>Last name:</td>
</tr>
<tr>
<td>Phone number (1):</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>Name of institution, if applicable:</td>
</tr>
</tbody>
</table>

**Name and Phone**
Enter the case’s full name (last, first, MI) and phone number(s).

**Address**
Enter the case’s address (street, city, and zip code) at time of diagnosis. This will usually be the case’s home address (whether permanent or temporary). Contact us if you have questions.

**Institution**
Enter the facility name if the case lives in a correctional facility, long-term care facility, or shelter at diagnosis.
Sources of Report
Select who reported the case to you: lab, physician, infection control or other. Enter the report source’s name and when the case was reported to you. Indicate whether the case was reported at death.

Section 3: DEMOGRAPHICS

<table>
<thead>
<tr>
<th>Demographics</th>
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<tbody>
<tr>
<td>Sex</td>
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<tr>
<td>Date of birth:</td>
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<tr>
<td>For pediatric TB (age &lt;15):</td>
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<tr>
<td>Lived outside US &gt;2 months?:</td>
</tr>
<tr>
<td>If yes, where?:</td>
</tr>
<tr>
<td>Guardian(s) country of birth:</td>
</tr>
<tr>
<td>Date of entry:</td>
</tr>
<tr>
<td>If yes, Plan name?:</td>
</tr>
</tbody>
</table>

Sex
Enter the biological sex of the case.

Date of Birth
Enter the case’s date of birth.

Pediatric TB – only fill out if the case is less than 15 years old
Select “Yes” if the case lived outside the US for more than two months. Enter where the case lived. Select “No” or “Unknown” as appropriate.

Enter the country of birth for each of the case’s guardians.

Race and Hispanic Ethnicity
Select the appropriate boxes to indicate self-identified race(s) and Hispanic or Latino ethnicity.

Country of Birth
Select “US” if the case was born in the United States, or born abroad to a U.S. citizen parent (e.g., born on a military installation).

Select “US Territory” and enter the location if the case was born in a US territory, island area, or outlying area (e.g., American Samoa, Federated States of Micronesia, Guam, Republic of the Marshall Islands, Commonwealth of the Northern Mariana Islands, Republic of Palau, Puerto Rico, U.S. Virgin Islands).

Select “Other” if the case was born outside the US or a US territory, and enter the patient’s birth country.

Date of Entry to US
If the case was born outside the US, enter the month and year the case first arrived in the US. If you don’t know the month, enter the year only.

Occupation
Select the case’s primary occupation within the past 12 months. If the case had multiple occupations, choose the one the case performed the majority of the time.
### Health Insurance
Indicate if the case has health insurance (Yes/No). If yes, list the plan name.

### Section 4: BASIS OF DIAGNOSIS

#### Site of disease
Select all sites of disease. If not pulmonary, pleural and/or lymphatic, write the site(s) in the space provided.

#### Symptomatic
Select whether the patient had TB symptoms. If symptomatic, enter the date symptoms started.

Mark yes, no, or unknown for the following symptoms:
- Cough – enter how long the patient has been coughing
- Hemoptysis (bloody sputum)
- Fever
- Night sweats
- Weight loss – enter amount of weight lost

If the case had a symptom that is not listed (e.g. lymphadenopathy, chest pain, fatigue), use the space provided to write it in.

Enter the date the case first sought medical care for TB symptoms, and where the case went for care.

If the case did not initially seek care for TB symptoms, select why the case was evaluated.

#### TST (tuberculin skin test) at diagnosis
Enter the date placed and result of the TST placed at diagnosis. Include the reading in millimeters. If not placed, mark “Not Done”.

#### QFT (Quantiferon) at diagnosis
Enter the date drawn and result of the QFT drawn at diagnosis. If not drawn, mark “Not Done”.

#### Prior TST/QFT
Enter the date and result of the last prior TST/QFT test, if known. Include the reading in millimeters.
Chest imaging at diagnosis

Enter the chest x-ray and/or chest CT date in the spaces provided. Select the result from the following:

<table>
<thead>
<tr>
<th>Selection options</th>
<th>Report shows</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative for TB</td>
<td>NO abnormalities consistent with TB</td>
</tr>
<tr>
<td>Abnormal non-cavitary, non-miliary</td>
<td>TB-associated abnormalities, but <strong>not</strong> cavitary or miliary</td>
</tr>
<tr>
<td>Abnormal, cavitary</td>
<td>TB-associated abnormalities, including cavitary findings</td>
</tr>
<tr>
<td>Abnormal, miliary</td>
<td>TB-associated abnormalities, including miliary findings</td>
</tr>
<tr>
<td>Not done</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Note: Please attach copies of all initial CXRs and CTs.

Section 5: BACTERIOLOGY

Enter the specimen source, date collected, lab results, and laboratory name for all specimens collected as part of the TB diagnostic evaluation. If done, indicate:

- AFB smear result
- NAAT/PCR/Xpert MTB/RIF assay result (from clinical specimens only)
- Culture/DNA probe result (from culture specimens only)
- Brief notes on any pathology (e.g., lymph node biopsy)

Example:

Since all testing in the example above took place at Legacy, you would submit all initial lab reports to us:

- 1/10/2017 sputum smear, NAAT, and culture
- 1/7/2017 lymph node smear and culture AND pathology report
- 1/11/2017 sputum smear and culture
Section 6: TB RISKS

TB HISTORY

| Patient name: |

<table>
<thead>
<tr>
<th>TB risks</th>
<th>Patient name:</th>
</tr>
</thead>
</table>

| TB history: |

<table>
<thead>
<tr>
<th>Previous diagnosis of TB disease?</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
<th>If yes, year</th>
<th>Was treatment completed*?</th>
<th>If yes, where:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous treatment for LTBI?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
<td>If yes, year</td>
<td>Was treatment completed*?</td>
<td>If yes, where:</td>
</tr>
</tbody>
</table>

Previous diagnosis of TB Disease
Check “Yes” if the case had TB disease (not LTBI) in the past. If yes, enter the year of diagnosis, if TB treatment was completed, and where.

Previous treatment for LTBI
Check “Yes” if the case was treated for LTBI in the past. If yes, provide year LTBI treatment was started. Indicate if the treatment was completed and where.

CONGREGATE SETTINGS

<table>
<thead>
<tr>
<th>Congregate settings:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Homeless in the past year?</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of homelessness?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Resident of correctional facility at diagnosis?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>History of incarceration?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Resident of long-term care facility at diagnosis?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

Homeless in the past year
Indicate if the case was homeless in the past 12 months.

There are many definitions for homeless. A homeless person may be an individual who has
1. No fixed, regular, and adequate nighttime residence
   and
2. A primary nighttime residence that is
   a. A supervised publicly or privately operated shelter designed to provide temporary living accommodations, including welfare hotels, congregate shelters, and transitional housing for the mentally ill
   or
   b. An institution that provides a temporary residence for individuals intended to be institutionalized
   or
   c. A public or private place not designated for, or ordinarily used as, a regular sleeping accommodation for human beings.

A homeless person may also be defined as a person who has no home (e.g., is not paying rent, does not own a home, and is not steadily living with relatives or friends). Persons in unstable housing situations (e.g., alternating between multiple residences for short stays of uncertain duration) may also be considered homeless.

History of homelessness
Check “Yes” if the case has a history of homelessness. Give details (when and where) if known.
Resident of a correctional facility at diagnosis
Check “Yes” if the case was evaluated for TB while in a correctional facility (federal, state, local, or juvenile detention center, etc.). Provide the facility name.

History of incarceration
Check “Yes” if the case has a history of incarceration. Specify details (when and where) if known.

Resident of long-term care facility
Check “Yes” if the case was evaluated for TB while in a long-term care facility (nursing home, assisted living, residential mental health or alcohol/drug treatment facility, etc.). Provide the facility name.

SOCIAL FACTORS

<table>
<thead>
<tr>
<th>Social factors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excess alcohol use in the past year?</td>
</tr>
<tr>
<td>IV drug use in the past year?</td>
</tr>
<tr>
<td>Non-IV drug use in the past year?</td>
</tr>
<tr>
<td>Currently smoking tobacco?</td>
</tr>
<tr>
<td>Tobacco type</td>
</tr>
<tr>
<td>Amount per day</td>
</tr>
<tr>
<td>Start year</td>
</tr>
<tr>
<td>Travel outside the US longer than 30 days?</td>
</tr>
<tr>
<td>If yes, when and where</td>
</tr>
</tbody>
</table>

Excess alcohol*, IV drug use, and non-IV drug use
Indicate if the case had excess alcohol use, IV drug use, and/or non-IV drug use in the past year. If information changes during the course of TB treatment, please update this question.

*There is no standard definition of excess alcohol use. Reliable indicators include:
- Participation in self-help programs (e.g., Alcoholics Anonymous) or alcohol treatment programs
- Medical record documentation of excess alcohol use or hospitalization for alcohol-related medical conditions (e.g., delirium tremens [DTs], pancreatitis, cirrhosis)

The National Household Survey on Drug Abuse defines heavy alcohol use as “five or more drinks on the same occasion on each of 5 or more days in the past 30 days”.
A standard drink in the United States is equal to 13.7 grams (0.6 ounces) of pure alcohol or
- 12 ounces of beer
- 8 ounces of malt liquor
- 5 ounces of wine
- 1.5 ounces or a “shot” of 80-proof distilled spirits or liquor (e.g., gin, rum, vodka, or whiskey)

Currently smoking tobacco
Indicate whether the case currently uses tobacco. List the type (cigarettes, cigars, pipe), amount per day, and estimated start year.

If not currently smoking, past tobacco smoking
If the case does not smoke now, indicate if the patient ever smoked tobacco. List the type (cigarettes, cigars, pipe), amount per day, and estimated start and quit year.

Travel outside the US longer than 30 days
If the case traveled outside the US for longer than 30 consecutive days, enter when and where.
MEDICAL RISKS

HIV at diagnosis
Enter the date and result of the case’s HIV test. All cases should receive HIV counseling and testing at TB diagnosis. A recent test result (within the last year) may be used. Update and resubmit as needed.

Medical and Other Risk Factors
Indicate if the case has any of the following conditions:

- Diabetes mellitus (Type I or Type II) at diagnosis
- Immunosuppressive therapy, such as high dose corticosteroids (e.g., prednisone)
- TNF α antagonist therapy for rheumatoid arthritis or other autoimmune diseases. Drugs may include infliximab (Remicade), etanercept (Enbrel), adalimumab (Humira), and golimumab (Simponi).
- End stage renal disease at diagnosis
- Post organ transplant – history of solid organ transplantation (e.g., renal, cardiac)
- Weight less than 90% of ideal body weight (case is undernourished)
- Cancer/malignancy – specifically immunosuppressive malignancies (e.g., leukemia, Hodgkin’s lymphoma, carcinoma of the head or neck)
- Other – TB risk factor not included in the above choices (e.g., intestinal bypass surgery for obesity, gastrectomy, jejunooileal bypass, chronic malabsorption syndromes, silicosis)
- Previous contact to an infectious TB patient
  - Check yes if the case was ever a contact to an infectious TB patient.
  - If yes, enter year of exposure.
  - Indicate if the index case was MDR (multi-drug resistant).
  - Enter any other relevant details (where exposure occurred, etc).
Section 7: TREATMENT

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Is therapy directly observed?</th>
<th>Pt height:</th>
<th>Pt weight:</th>
<th>History of hepatitis or other liver dysfunction</th>
<th>If yes, provide details:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isoniazid</td>
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<td>Rifampin</td>
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<td>Pyrazinamide</td>
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<td>Ethambutel</td>
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</table>

Date therapy started
Enter the date (month, day, year) the case started multi-drug therapy for treatment of TB disease.

Regimen
Indicate the initial drug regimen prescribed for TB treatment. List the dosage and frequency of each drug.

Is therapy directly observed?
Indicate if therapy will be directly observed. Directly observed therapy (DOT) is the standard of care in Oregon. If not DOT, please state the reason in the space provided.

Height, weight, history of hepatitis or liver dysfunction
Indicate the case’s height, weight, and history of hepatitis or liver dysfunction. List any relevant details.

Section 8: VERIFICATION

<table>
<thead>
<tr>
<th>Laboratory confirmed</th>
<th>Clinical case</th>
<th>Provider treating empirically</th>
<th>Not TB: Other diagnosis</th>
</tr>
</thead>
</table>

Indicate the case’s verification status. For non-laboratory confirmed cases, obtain status from treating physician.

Laboratory confirmed
Select this box if the case has a culture or NAAT result that is positive for M tuberculosis complex.

Clinical case
Select this box if the case is culture/NAAT negative, but the clinical picture (including positive TST or QFT, complete diagnostic evaluation) indicates TB, and case improves on treatment.

Provider treating empirically
Select this box if the case is not laboratory confirmed or clinical, and the provider is continuing TB treatment (TB not ruled out).

Not TB
Select this box if TB is no longer considered as a diagnosis. Indicate other diagnosis in space provided.
Section 9: CLOSURE

Select the reason for closure of the TB case from the choices below:

**Not TB:** The completed diagnostic evaluation indicates the case does not have TB.

**Completed therapy:** Treatment for TB disease has been completed.

**Lost:** The case cannot be located prior to the completion of treatment (e.g., the case moved and no locating information is available, or the case can’t be located based on available information).

**Refused/non-compliant:** The case refused to complete therapy (e.g., stopped taking drugs).

**Died:** The case was alive at diagnosis, but died before therapy was completed.

**Adverse treatment event:** Therapy was permanently stopped due to an adverse treatment event from TB medications (e.g., life threatening drug reaction).

If the case started treatment, fill out the following sections.

**Treatment stop date**
Enter the date the case stopped taking therapy for TB disease or suspected TB disease.

**If treatment greater than 12 months, why?**
Possible reasons for extended treatment include rifampin resistance, significant adverse drug reaction, non-adherence, failure to convert sputum culture in 2 months, TB meningitis, severe liver disease, etc.

**Type of outpatient healthcare provider**
Choose the provider(s) with primary responsibility for clinical outpatient decision making (excluding diagnostic work-up, contact investigations, anti-TB medications, and DOT).
Response to treatment

Did sputum culture convert? *(Only answer for cases with at least one positive sputum culture)*

If “Yes”, enter the date when the first consistently negative sputum culture was collected (no positive cultures collected after this date). It should be ≥ 7 days after the last positive culture collection.

If “No”, enter reason for non-conversion (e.g., case died, lost, or refused; case clinically improved, no follow-up sputum collection attempted, patient unable to produce sputum).

Enter NA if there were no initial positive sputum cultures or sputums were not done.

Did CXR or CT improve? Indicate if follow-up CXR or CT improved. Enter NA if extrapulmonary and/or CXR not performed. Please attach reports.

Did symptoms improve? Indicate if symptoms improved. Enter NA if patient was asymptomatic.

Treatment doses

In reporting LHD
Enter the number of directly observed doses taken while on daily, three times a week, or alternative schedule DOT.

If the case is on full DOT, do not list doses taken on weekends or federal holidays as non-DOT doses.

Non-DOT doses only need to be entered for cases on self-administered therapy.

DOT

Fully directly observed
Check if the case received full DOT. For patients on daily regimens a full DOT week is 5 or more observed doses in a 7 day week, with the exception of government holiday weeks where 4 doses in a 7 day week is acceptable. Also allowable for classification as full DOT is self-administered therapy for 1 vacation week during the continuation phase. Any self-administered therapy greater than 1 week must be added on to the end of the regimen in order for treatment to be considered fully directly observed.

Self-administered
Check if the case did not receive any directly observed doses during treatment.

Both directly observed and self-administered
Check if the case received both directly observed and self-administered therapy (i.e., the requirements of full DOT as specified above were not met).

Comments
Enter any comments in the space provided.