



OREGON HEALTH AUTHORITY

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Tuberculosis Program

# TB Case Report & Data Entry Manual

## Preface

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Beginning January 1, 2019, LPHAs must submit all TB case reports electronically via Orpheus (The Oregon Public Health Epidemiologists' User System). After this date, the TB Program, Oregon Health Authority (TB-OHA) will no longer accept paper reports.

Suspected or confirmed TB cases must be reported to TB-OHA via Orpheus within 5 business days after the report is received by the LPHA. TB-OHA uses the TB module in Orpheus to collect data on TB cases and contacts. This data is reported to the CDC and analyzed internally for statewide TB control and prevention activities.

These instructions describe using Orpheus to report TB cases and give detailed instructions on how to open a case and complete data entry. More detail about data definitions are available on the CDC website at <https://www.cdc.gov/tb/programs/rvct/default.htm>. These instructions are not a substitute for expert clinical opinion or CDC guidelines on medical TB management. Please contact TB-OHA with questions on TB diagnosis and case management.

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## The TB Case Report: Overview

*Beginning January 1, 2019, all TB case reporting will be completed in Orpheus. Faxed or e-mailed paper reports will no longer be accepted after this date.*

### When to report

Make a report in Orpheus within 5 business days whenever:

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

### When to update

The case record should be updated when the case is confirmed to have TB disease or TB is ruled out. If the case did not have a positive lab but was started on treatment, a TB diagnosis is typically confirmed if the patient improves after two months of treatment. Update and close the record when treatment is complete.

## How to report

Report confirmed cases of TB by opening a TB case in Orpheus and completing data entry. If an LPHA receives a lab confirmation of TB disease or a report from a provider indicating TB treatment is being started, the LPHA should open a case in Orpheus and complete patient demographic information and the following tabs in their entirety according to the information available at the time of report:

1. Admin
2. Labs
3. Clinical
4. Treatment
5. Risks
6. Follow-up

Contact data entry is covered in [Section 4](#) of this guide.

### **If an LPHA receives a confirmed or presumptive report from a provider or lab**

The LPHA should attach to the Docs tab copies of the radiology report, pathology reports, and/or lab reports generated at any lab other than the Oregon State Public Health Lab. If the above documents are not available at time of report, attach them immediately upon receipt.

If the case is laboratory confirmed at time of report (i.e., there a positive NAAT or culture lab result), enter verification status “Confirmed.” If the case is not confirmed at time of initial report, enter status as follows:

- If the case has started treatment but is not a confirmed case, enter “Unconfirmed, started Tx”;
- If the case is neither confirmed nor started on treatment, status can be entered as “Presumptive” at the LPHA’s discretion. This status is optional and for LPHA tracking purposes only. Data collection and entry for Presumptive cases is not required.

**If TB-OHA receives a confirmed lab report via ELR or fax**

The TB Epidemiologist will open a case in Orpheus and enter the verification status, lab results, and demographic information from the lab report.

The TB Epidemiologist will notify via e-mail the LPHA responsible for the case.

The LPHA nurse case manager will complete demographic information and the following tabs in their entirety, as applicable, within five business days of report:

- Admin
- Labs
- Clinical
- Treatment
- Risks
- Follow-up

**Case confirmation**

Once a TB case is confirmed (whether confirmed at time of report or after confirmation by subsequent lab report or provider verification), the TB Epidemiologist assigns a case number and count date. The Epidemiologist follows-up with the LPHA to complete any information missing in the case record.

LPHA staff attaches to the Docs tab supporting documentation (e.g., radiology reports, case notes, or lab reports originating from labs other than OSPHL) as deemed relevant by the TB nurse case manager and/or TB-OHA staff;

- The TB Epidemiologist processes ELRs, edits ELRs, and attaches them to the case Labs tab unless another arrangement has been made with the LPHA in advance;
- LPHA staff documents completion of treatment in Orpheus.

## **If TB is ruled out**

If an unconfirmed case on treatment or a presumptive case is ruled out as TB, the LPHA or TB-OHA changes the case status to “No case” and creates a note in the Orpheus case record explaining and documenting the change of status.

## **Data Quality Assurance (QA)**

TB-OHA conducts case QA review of Orpheus case and contact investigation records to ensure completeness and accuracy. Based on QA review, TB-OHA may request data completion by an LPHA to meet deadlines for CDC reporting and local surveillance analysis.

## **Case Closure**

The LPHA enters case closure information on the Treatment tab including date treatment stopped, reason treatment was stopped, and DOT status. The TB Epidemiologist will calculate and enter weeks of DOT.



## Case reporting in Orpheus

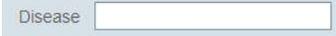
**Case reporting in Orpheus requires completion of the following information and tabs**

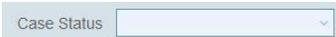
- ✓ Demographic information
- ✓ Admin Tab
- ✓ Labs Tab
- ✓ Clinical Tab
- ✓ Treatment Tab
- ✓ Risks Tab
- ✓ Follow-up Tab

*Case creation and data entry are outlined in detail in the following sections.*

## Creating the case report

- ✓ On the Orpheus home page, click on  to create a new case record. A pop-up window will appear. Complete the following fields:

**Disease** Select TB from the dropdown. 

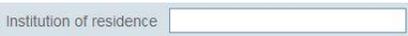
**Case Status** Enter case confirmation status. See page [5](#) for status assignment guidelines. 

- Confirmed
- Unconfirmed, started tx
- Presumptive

**Name** Enter first and last name. 

**Date of Birth** Enter date of birth. 

**Sex** Enter current sex. 

**Institution of Residence** Enter institution of residence at diagnosis if applicable (correctional facility, long-term care facility or shelter). 

**Address** Enter residence address. This will usually be the case’s home address, whether permanent or temporary. 

County will auto-populate based on Zip code.

Click “Create Case”.

**T B C A S E R E P O R T I N G & D A T A E N T R Y M A N U A L**

Orpheus will search name and DOB for matching person records. If a list of potential matches appears, check the list for an exact match. If a match appears, click “create case” (1) next to the name to create the new case. If no match appears, click “Ignore Matches – Create Person and Case” (2). If no potential matches are found, the new case window will appear without displaying the potential matches.

If one of these people is the person you want to enter a case for, click 'Create Case,' or click 'Details' for more info.

Initial data:  
Winter Persimmon DOB:  
1234 Main St Sandy  
Disease: TB

Last Name	First Name	MI	DOB	Sex	Race	Birth Country	Cases
Person	Wesley	M	1/26/2011	M			(1) Create Case Details

(2) Ignore Matches  
Create Person and Case

## Demographic Information

- ✓ Enter demographic information on the central panel that appears on every page of the TB module. Every field above the “STATE USE ONLY” area is required. Most fields are filled by choosing from the drop-down options. Choose from the drop-down options only. Do not overwrite drop-down options with free text. Do not enter any information in the “STATE USE ONLY” fields.

**Orpheus Case ID** Auto-generated.

**Name, Disease, Status, DOB, Age, Sex, Address** Auto-populated based on information entered in the New Case Investigation window.

**Pediatric case** If the case is less than 15 years old, a pediatric information box will appear. If the pediatric case lived outside the U.S. for two months or more, select “yes” and indicate where the case lived. Enter birth country for guardian(s).

**Deceased** Enter “No” if case was alive at diagnosis. If the case dies during treatment, update this field with date and cause of death.

**Current Sex** Sex auto-populates as “Current Sex.” Sex at birth and gender are optional fields.

<b>Pregnancy</b>	If the case is a female, a Pregnancy box will appear. Enter yes, no, or unknown. If yes, enter estimated due date if known.
<b>Race (REALD)</b>	<i>This item is pending system-wide revision.</i> Enter self-identified Race, Sub-race, and Hispanic ethnicity from the dropdown options. Do not overwrite dropdown options with free text.
<b>Language</b>	<i>This item is pending system-wide revision.</i> Select Language from the dropdown options. If the language is not listed, overwrite the language with free text.
<b>Country of Birth</b>	Select country of birth from the drop-down options. Do not enter free text. Select “United States” if the case was eligible for U.S. Citizenship at birth. If the case is known to be a refugee, click the “Refugee” box.
<b>Occupation and Work</b>	Enter Occupation category from the dropdown options. Enter the case’s <u>primary</u> occupation within the past 12 months. If the case had multiple occupations, choose the one the case performed the majority of the time. Enter a brief description of the worksite or job description as free text.
<b>Address and Phone number</b>	Address and phone number auto-populate from the Case Creation Window if entered at case creation. Check and confirm address and LPHA jurisdiction. If jurisdiction appears incorrect, contact TB-OHA. If address and phone number are not entered at case creation, enter these items.

## TAB: Administrative

- ✓ Enter report dates, case epidemiologists, and treating provider information on the Admin tab.

### Report Dates

Enter the date the initial report is received by the LPHA. Enter the date the report is made to the State.

Received by LHD:		
Date Reported to State:		

### Case Epi

By default, the Epi is automatically assigned to the person creating the case. The State Epi is always the State TB Epidemiologist (currently Kiley Ariail). The Local Epi is the nurse case manager responsible for the case. Make sure this information is correct in the EPIs dropdown boxes.

<b>EPIS</b>	
State Epi	Kiley Ariail
Local Epi	

### Treating Provider

Specify the treating provider, if known. Clicking the “+ Provider” button allows you to search for and select the provider name.

TREATING PROVIDER	Provider
<hr/>	

## TAB: Lab Summary

- ✓ Enter preliminary lab results. All fields are required. Spaces are provided for TST and/or IGRA, Radiology, Sputum smear and culture, NAAT test, and tests of other tissue and body fluids. Do not overwrite any drop-down choices. The choices are set to conform to CDC reporting requirements.

### TST/IGRA at Diagnosis

TST: Enter the date placed and result of the TST placed during the current diagnostic evaluation. Previous positive test results may be entered if the result is documented. Include the reading in millimeters. If not placed, mark “Not Done”.

TST/IGRA at Diagnosis	Date	Induration (mm)
TST:	result...	
IGRA:	result...	

IGRA (Quantiferon or T-spot): Enter the date drawn and result of the IGRA drawn during the current diagnostic evaluation. If not drawn, mark “Not Done”.

RADIOLOGY at Diagnosis	Exam Date	If abnormal
Chest X-Ray:	Result...	
Chest CT:	Result...	

### Chest imaging at Diagnosis

Enter the chest x-ray and/or chest CT date in the spaces provided.

Enter the imaging result:

- Normal: NO abnormalities consistent with TB
- Abnormal: TB-associated abnormalities
- Unknown: Imagine done, result unknown
- Not done

If the result is abnormal, enter the descriptor:

- Cavitory: Cavitory findings
- Miliary: Miliary findings
- Both: Both cavitory and military findings
- Neither: abnormal findings, neither cavitory nor military

**Sputum  
Bacteriology**

Enter results of sputum examinations collected as part of the diagnostic evaluation or shortly thereafter. Do not record results of specimens collected after case has been on treatment for more than 2 weeks.

SPUTUM		Collection Dt	Result Date
Sputum Smear:	Result...		
Sputum Culture:	Result...		
Laboratory Type:			

**Sputum Smear:**

- Enter “positive” if the result of **any** sputum smear is positive for acid-fast bacilli (AFB). If several sputum samples were collected and the result of one or more smear tests is positive, enter the date and result for the first sputum specimen with a positive result.
- Enter “negative” if the results of **all** sputum samples examined are negative. If several sputum samples were collected and all results are negative, enter the date the first negative sputum sample was collected.
- Enter “not done” if it is known that a sputum smear was not done.
- Enter “unknown” if it is not known whether a sputum smear was done OR if results are not known for a reason other than pending results (e.g., result was lost or specimen was contaminated and no other specimen can be obtained).
- If an initial sputum specimen was collected and results are unknown, but later become known, update the results.

**Sputum Culture:**

- Enter “positive” if **any** sputum culture is positive for *M. tuberculosis* complex. If several sputum samples were cultured and the result of one or more cultures is positive for *M. tuberculosis* complex, enter the date and result for the first sputum culture with a positive result.
- Enter “negative” if the results of **all** sputum cultures are negative. If several sputum samples were collected and all results are negative, enter the date the first negative sputum culture was collected.
- Enter “not done” if it is known that a sputum culture was not done.
- Enter “unknown” if it is not known whether a sputum culture was done OR if results are not known for a reason other than pending results (e.g., result was lost or specimen was contaminated and no other specimen can be obtained).
- If an initial sputum specimen was collected and results are unknown, but later become known, update the results.

**Collection Dates:**

- Enter the date the **first** specimen with a positive smear or culture result was collected. If several specimens were tested and one or more were positive, enter the date the **first** specimen with a positive result was collected.
- If no positive result was obtained, enter the date the **first** specimen with a negative result was collected. If several specimens were tested and all were negative for *M. tuberculosis*, enter the date the **first** specimen with a negative result was collected.

**Result Date:**

- Enter the date the **first** positive culture result was reported. This date can be found on the laboratory report as the report date or release date.
- If more than one specimen was tested, and all are negative, enter the date the **first** negative result was reported.

**Laboratory Type:** Select the option that best describes the reporting laboratory type

- **Public Health Lab:** Most often Oregon State Public Health Lab. Any laboratory associated with a state or local health department
- **Commercial Lab:** Any lab that charges a fee for each specimen processed or test performed (e.g., Quest, Interpath)
- **Other:** Any other laboratory that is not considered a public health lab or commercial lab. Most often, hospital labs (e.g., Providence, Legacy, OHSU, Kaiser, National Jewish). Also labs associated with federal public health agencies (e.g., CDC, Indian Health Service, or Bureau of Prisons).

### Nucleic Acid Amplification Testing (NAAT)

NAAT testing may be done on sputum or other primary clinical

NUCLEIC ACID AMPLIFICATION		Collection Dt	Result Date	Source of specimen...
NAAT:	Result...			
Laboratory Type:				

specimens. NAAT testing is not done on culture isolates. NAAT results may reference GeneXpert, PCR, or RT-PCR. If a NAAT is performed on more than one primary clinical specimen, enter the results of the first positive test.

Do not overwrite any drop-down choices. The choices are set to conform to CDC reporting requirements.

#### Result:

- Enter “positive” if **any** NAAT result was positive for M. tuberculosis complex.
  - Any positive result supersedes all other test results (e.g., 1 positive and 2 negatives = positive; 1 indeterminate and 1 negative and 1 positive = positive).
- Enter “negative” if **no** NAAT result was positive for M. tuberculosis complex and at least one result was negative.
  - A negative result supersedes an indeterminate (e.g., 1 negative and 1 indeterminate = negative).
- Enter “indeterminate” if **all** NAAT results were indeterminate (e.g., inconclusive or inhibited).
- Enter “not done” if NAAT was **not** performed.
- Enter “unknown” if it is not known whether a NAAT was performed or if NAAT results are not known for a reason other than pending results.

#### Collection Date:

- Enter the date the first specimen with a positive result was collected. If several specimens were tested and one or more were positive for M. tuberculosis, enter the date the first specimen with a positive result was collected.
- If no positive result was obtained, enter the date the first specimen with a negative result was collected. If several specimens were tested and all were negative for M. tuberculosis, enter the date the first specimen with a negative result was collected.

#### Result Date:

- Enter the date the first positive NAAT result was reported. This date can be found on the laboratory report as the report date or release date.

- If more than one specimen was tested, and all are negative or indeterminate, enter the date the first negative or indeterminate result was reported.

**Specimen Source:**

- Select specimen source from the dropdown options. Do not overwrite options. If you need assistance selecting specimen source, contact the TB Epidemiologist.

**Laboratory type:**

- See options above in Sputum Bacteriology.

**Smear/Pathology  
/Cytology of  
Tissue & Other  
Body Fluids**

This section is for recording results of a smear, pathology, or cytology of tissue and/or other body fluids not including sputum. Examples of other tissue/fluid types include bronchial cells and fluid, tracheal aspirate, lymph node, lung tissue or fluid, pleural fluid, cerebral spinal fluid, etc. The specimen entered for smear, pathology, or cytology should have been obtained during a diagnostic workup or shortly thereafter. Do not record specimens collected after the patient has received treatment for more than 2 weeks.

TISSUE & OTHER BODY FLUIDS		Collection Dt	Source of tissue/other specimen:
Lab Test:	Pos		Source of specimen...
Exam Type:	<input type="radio"/> Smear <input type="radio"/> Pathology/Cytology <input type="radio"/> Both		

Do not overwrite any drop-down choices. The choices are set to conform to CDC reporting requirements.

**Result:**

- Enter “positive” if any tissue or body fluid other than sputum tests positive by smear examination or shows granulomas, granulomatous inflammation, or other pathologic or histologic findings consistent with TB disease during a pathologic/cytologic examination.
  - If more than one specimen is examined, any positive result supersedes a negative result.
- Enter ‘negative’ if all specimens of tissue or body fluid other than sputum tested negative by smear examination or showed no evidence of granulomas, granulomatous inflammation, or other pathologic or histologic findings consistent with TB disease during a pathologic/cytologic examination.
- Enter “not done” if no pathologic/cytologic examinations are done.
- Enter “unknown” if it is not known whether tissues or fluid other than sputum were examined or results are not known for a reason

other than pending results (e.g., result was lost or specimen was contaminated and no other specimen can be obtained).

**Collection date:**

- Enter the date the first specimen with a positive result was collected. If several specimens were tested and one or more were positive, enter the date the first specimen with a positive result was collected.
- Enter the date the first specimen with a negative result was collected. If several specimens were tested and all were negative, enter the date the first specimen with a negative result was collected.

**Specimen Source:**

- Select specimen source from the dropdown options. Do not overwrite options. If you need assistance selecting specimen source, contact the TB Epidemiologist.

**Exam Type:**

- Select the type of exam that corresponds to the result selected above.
    - Smear
    - Pathology/Cytology
    - Both
- ✓ *Any positive result supersedes a negative result in reporting TB diagnostic criteria. If the results are discrepant (e.g., smear negative, pathology positive) then Type of Exam should correspond to the positive result. If both smear and pathology are positive, “both” should be checked under Exam Type. Likewise, if both smear and pathology are negative, “both” should be checked under Exam Type.*

**Culture of Tissue & Other Body Fluids**

“Tissue and Other Body Fluids” does not include sputum. Examples of other tissue/fluid types include bronchial cells and fluid, tracheal aspirate, lymph node, lung tissue or fluid, pleural fluid, cerebral spinal fluid, etc. The specimen entered for culture should have been obtained during a diagnostic workup or shortly thereafter. Do not record specimens collected after the patient has received treatment for more than 2 weeks.

		Result Date	
<b>Tiss/Oth Culture:</b>	Result...		Source of specimen...
<b>Laboratory Type:</b>			

Do not overwrite any drop-down choices. The choices are set to conform to CDC reporting requirements.

**Result:**

- Enter “positive” if **any** tissue or body fluid culture other than sputum is positive for *M. tuberculosis* complex. If an initial specimen was collected and results are unknown, but later become known, update the results.
  - If more than one specimen is cultured, any positive result supersedes a negative result.
- Enter ‘negative’ if **all** tissue or body fluid cultures other than sputum are negative for *M. tuberculosis* complex.
- Enter “not done” if it is known that no tissue or fluid cultures other than sputum were done.
- Enter “unknown” if it is not known whether tissue or fluid cultures other than sputum were performed or results are not known for a reason other than pending results (e.g., result was lost or specimen was contaminated and no other specimen can be obtained).
  - If an initial specimen was collected and results are unknown, but results later become known, update the results.

**Collection date:**

- Enter the date the first specimen with a positive result was collected. If several specimens were cultured and one or more were positive for *M. tuberculosis* complex, enter the date the first specimen with a positive culture result was collected.
- If no positive result was obtained, enter the date the first specimen with a negative result was collected. If several specimens were tested and all were negative, enter the date the first specimen with a negative result was collected.

**Specimen Source:**

- Select specimen source from the dropdown options. Do not overwrite options. If you need assistance selecting specimen source, contact the TB Epidemiologist.
- ✓ *The notes box can be used to record any additional detail on tests, tissue specimens, or results.*

## TAB: Labs

- ✓ This is the tab where lab reports are displayed. Completion of the labs tab is not required to report a case.
- ✓ Reports received and processed via ELR will be displayed. Manual addition of reports received via fax or other method can also be uploaded to display here. Processing of ELRs is not covered in this manual.
- ✓ To manually add a lab report received via fax or other method
  - Click **+ Specimen**. A window with fields for lab report details appears.
  - Fill in the laboratory performing the test, the specimen collection date and the report dates. Choose Specimen Type from the dropdown. Overwrite dropdown choices as needed. Fill in Test Type, Result, and Interpretation.

<b>Laboratory:</b>	
<b>Origin. Lab:</b>	
<b>Collection Date:</b>	Collection Date...
<b>Report Date:</b>	Lab Result Date...
<b>Specimen Type:</b>	Type... ▾
<b>Test Type:</b>	Type... ▾
<b>Test Method:</b>	State Use Only
<b>Result:</b>	Result...
<b>Interpretation:</b>	Interpretation...
<b>Accession ID:</b> Accession ID...	
Comments	^   v

## TAB: Clinical

- ✓ Enter clinical information. All fields are required.

### Symptomatic

Indicate whether the case displayed symptoms at initial evaluation. If symptomatic, enter date of symptom onset if known.

CLINICAL

Symptomatic?  Y  N  ?

Reason for TB Evaluation:

Symptom Onset

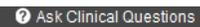
### Reason for TB Evaluation

Enter reason for TB evaluation from the dropdown choices. Do not overwrite dropdown choices.

- **TB Symptoms:** Case sought medical care for signs and symptoms consistent with TB (e.g., prolonged persistent cough, fever, lymphadenopathy, night sweats, weight loss).
- **Contact Investigation:** Case was evaluated as a result of contact investigation.
- **Targeted testing:** Case was evaluated after a positive TST or IGRA administered specifically because the case was considered high risk for TB (e.g., persons from area of the world with high risk for TB) or as a part of a testing program focused on specific groups at high risk for TB. Do not select if another reason (e.g., contact investigation, immigration medical exam, etc.) is more appropriate.
- **Employment/Admin screening:** Case was evaluated for employment. Refers to an administrative requirement rather than testing a group considered at high risk.
- **Health Care Worker screening:** Case was evaluated after a positive TST or IGRA administered for employment at a health care facility. Includes paid and unpaid workers. For health care workers being evaluated for TB disease, this choice supersedes targeted testing and employment/administrative screening. Other situations (e.g., TB symptoms, contact investigation) supersede health care worker.
- **Immigration:** Case was evaluated as an immigrant or refugee (B-waiver) on entry to the U.S. or as a status adjuster.
- **Incidental Abnormal CXR/CT or Incidental Abnormal lab result:** Case was identified as a result of a clinical evaluation for something other than TB (e.g., bronchoscopy or autopsy). Specimens were collected and tested for diagnostic completeness. TB was not expected.

- Unknown: Reason for evaluating the case was not known.
- Other: Enter reason in pop-up box.

**Clinical Questions**

Enter answers to clinical questions by clicking  and answering the questions in the pop-up boxes. Mark yes, no, or unknown for the following symptoms:

- Cough – enter how long the patient has been coughing
- Fever
- Night sweats
- Hemoptysis (bloody sputum)
- Weight loss – enter amount of weight lost
- If the case had a symptom not listed (e.g. lymphadenopathy, chest pain, fatigue), enter under “other clinical symptoms”.



**Site(s) of Disease**

Indicate site(s) of disease by checking the most appropriate option. If site of disease is not listed, choose the site from the dropdown choices in the Other box. Do not overwrite these choices.

Contact the TB Epidemiologist for help with choosing the site if needed.



**HIV Status at Diagnosis**

Enter HIV status at diagnosis. All cases must be tested for HIV. An undocumented report of HIV status is NOT acceptable. If the case is HIV positive, contact the TB Epidemiologist.



## TAB: Treatment

**Treatment Start Date**

Enter date patient started multi-drug therapy.

Date Started  

**Deceased at Diagnosis**

Select the radio button indicating whether the patient was deceased at time of diagnosis.

Deceased at TB Diagnosis  Y  N

**Height & Weight**

Enter the patient’s height and weight at time of diagnosis. Check <90% Ideal Body Weight if appropriate.

Height   
 Weight   
 < 90% Ideal Body Weight

**Expected Length of Treatment**

Enter the expected length of treatment if known. Use free text.

Expected Tx Length

✓ *Date stopped, closure, treatment extension, DOT, DOT weeks, and Provider(s) will be entered when the case completes treatment.*

**Initial Drug Regimen**

These fields are for initial drug treatment/initiation phase regimen only. Enter only initial/initiation phase regimen.

Initial Drug Regimen			+ Treatment
Drug Name / Comment	Dosage	Frequency	
Isoniazid (INH)	Dosage... mg.	<input type="text"/>	✘
Rifampin (RIF)	Dosage... mg.	<input type="text"/>	✘
Pyrazinamide (PZA)	Dosage... mg.	<input type="text"/>	✘
Ethambutol (EMB)	Dosage... mg.	<input type="text"/>	✘
Vitamin B6	Dosage... mg.	<input type="text"/>	✘

Do not change these fields when the drug regimen changes to continuation phase or if treatment changes for any other reason.

The RIPE+B6 regimen is auto-populated in the drop-down boxes. Enter the dosage as numbers only. Enter the dose frequency.

If the case is taking an alternative initial regimen, add a drug to the regimen by clicking  Treatment. An additional drop-down will appear. Choose the drug from the dropdown choices. Do not overwrite dropdown choices.

Remove drugs from the initial regimen as needed by clicking the ✖ at the end of the drug row

## TAB: Risks

- ✓ Enter answers to risk questions by clicking  and answering the questions in the pop-up boxes. Guidance for answering each question is included on the question interface.

## TAB: Follow-Up

- ✓ Enter answers to follow-up questions by clicking  and answering the questions in the pop-up boxes.

### Immigration Status

TB-OHA does not collect or report immigration status information. If a case was born outside of the United States, Immigration Status at Entry to U.S. and Immigration Status Current should be entered as “Unknown.”

Question
Immigration - At Entry to US
Immigration - Current

### Immigration Date

Enter date of entry to US if known. Enter month and year in the format MM/YYYY. If month is unknown but year is known, enter 99/YYYY. If both month and year are unknown, enter 99/9999.

Date of Entry to US

### Health Insurance

Indicate if the case has health insurance. If yes, enter plan name in free text.

Health Plan
Health insurance



## **Closing a Case in Orpheus**

**When treatment is complete, close the case by completing information in the following tabs:**

- ✓ Treatment
- ✓ Central Static Pane
- ✓ Admin

## CLOSURE TAB: Treatment

### Treatment Stop Date

Enter the date the patient stopped treatment. This is the date on which the patient last ingested medication for TB disease or suspected TB.

Date Stopped

### Closure Reason

Enter Closure reason. Select closure reason from the dropdown choices. Do not overwrite choices.

Closure

- Completed therapy: Case completed prescribed course of treatment.
- Lost: Case could not be located before the start or end of treatment (e.g., the case moved to an unknown location or the forwarding address is known but the case could not be located at that address). Code cases who move outside the U.S. and cannot be followed up as “Other”.
- Uncooperative/refused: Case refused to complete treatment (e.g., stopped taking drugs).
- Adverse treatment event: Treatment was permanently stopped because of an adverse event due to anti-TB medications.
  - If the case died because of an adverse TB treatment event, select:
    - Closure reason: “Died” and then select
    - Deceased: “Yes” in the static demographic panel and “Related to Treatment” for reason for death.
- Not TB: Diagnostic evaluation did not substantiate the diagnosis of TB (e.g., *M. avium* was isolated from a clinical specimen).
- Died: Case was alive at diagnosis but died before the start or completion of treatment.
- Other: Treatment was discontinued for a known reason not included in the above choices and is not unknown. A case who moved out of state and the receiving state never followed up would fall into this category, as would cases who move internationally and are lost to follow-up due to international relocation.

**Treatment Extension**

Enter reason for treatment extension if duration of treatment was greater than 12 months. Select closure reason from the dropdown choices. Do not overwrite choices.

Treatment Ext.

- Rifampin resistance: Rifampin-resistant or multi-drug resistant TB requiring a treatment protocol lasting more than 12 months.
- Adverse drug reaction: Adverse drug reaction that prolonged therapy.
- Non-adherence: Non- adherence resulted in treatment beyond 12 months (e.g., treatment interruption).
- Failure: A sputum specimen tested culture positive four or more months after treatment began.
- Clinically indicated – other reasons: Clinical indications other than adverse drug reactions include CNS TB, severe liver disease, or other criteria specified by clinician.
- Other: Reason does not include any of the choices listed above.

**Provider Type**

Enter the type(s) of medical provider(s) that provided treatment.

**Provider(s)**

Local/State Health Department (HD)

Private Outpatient

IHS, Tribal HD, or Tribal Corporation

Institutional/Correctional

Inpatient Care Only

Unknown

Other...

**Directly Observed Treatment (DOT)**

Enter Directly Observed Therapy. Select observation type from the dropdown choices. Do not overwrite choices.

DOT

DOT Weeks

- Totally directly observed: Applies if DOT was used for all doses for a case who was taking medication. Also applies if a case was taking medication 7 days a week and DOT was used for at least 5 of those days (e.g., case self-administered on weekends and holidays).

**T B C A S E R E P O R T I N G & D A T A E N T R Y M A N U A L**

- Totally self-administered: Applies if NO doses of medication were given under direct supervision.
- Both: Applies if the case self-administered any doses while taking medication. Does not apply if the case was taking medication 7 times a week and DOT was used for at least 5 of those doses. Response also applies if case took several months of DOT and several months of self-administered treatment.

✓ *DOT weeks will be calculated and entered by the TB Epidemiologist.*

## CLOSURE: Central Panel

### Deceased

If closure reason on the Treatment tab is “Died”, enter Deceased = “Yes” and

The screenshot shows a form with the following fields: DOB, Age, Deceased: [Not Answered], Sex, Race, and Sub. The Deceased field is highlighted in yellow. To the right of the form is a modal window titled 'Deceased?' with radio buttons for 'Yes' and 'No', a 'Date' field with a calendar icon, and a 'Cause' text input field.

indicate date of death and cause of death from the dropdown choices. Do not overwrite dropdown choices.

- Related to TB Disease: TB was the immediate cause, TB was an underlying cause, or TB was another significant condition contributing to death (even if TB was not the main cause of death).
- Related to TB Therapy: An adverse treatment event was related to the cause of death.
- Unrelated to TB disease: TB was NOT the immediate cause, an underlying cause, or another significant condition contributing to death.
- Unknown: Cause of death was unknown.

## CLOSURE TAB: Admin

**LHD Completion Date**

Enter the date case was closed and case record completed by the Local Public Health Authority.

The TB Epidemiologist will enter the State Completion Date.

<b>LHD Completion Date:</b>	<input type="text"/>	
<b>State Completion Date:</b>	<input type="text"/>	

**Moved During Treatment**

If case changed primary residence during treatment, enter that information.

<b>MOVED</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="checkbox"/> Out of US-Transnational Referral
Where?	<input type="text"/>	City <input type="text"/>
		County <input type="text"/>
		State <input type="text"/>

- Enter “No” if case did not move during treatment.
- Enter “No” if the patient moved within the same local public health authority jurisdiction during treatment.
- Enter “Yes” if the case moved to another jurisdiction.
  - Select “In-state, out of jurisdiction” if case moved within the state but out of the original treating jurisdiction. Enter the city and county to which the case moved.
  - Select “Out of state” if case moved from the original treating state to another of the 50 United States or the District of Columbia or to a U.S. Territory, U.S. Island Area, or a U.S. Outlying Area. Enter the name of the state or reporting area to which the case moved.
  - Select “Out of the U.S.” if the case moved from the U.S. to another country. Enter the name of the country to which the case moved. Also check the “Out of US-Transnational Referral” box if a transnational referral was made.



## Contact Investigation Data Entry

### Three Essential Points

- ✓ *LPHAs are required to enter contact investigation information directly into the Contact Investigation tab in Orpheus. LPHAs are not required to submit the TB Contact Investigation Form to the State TB Control Program.*
- ✓ *LPHAs are free to use the TB Contact Investigation Form to 1) prioritize the follow-up of contacts and 2) track the evaluation and treatment of contacts, however, use and submission of the form is not required. The form is available on the State TB Control Program website at:  
<https://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/Tuberculosis/Documents/formdoc/contactformRIF.pdf>*
- ✓ *The following data entry instructions are not a substitute for guidelines about TB diagnosis, treatment, or control. Please refer to “Guidelines for the Investigation of Contact of Persons with Infectious Tuberculosis” (MMWR December 16, 2005 vol. 54, no. RR-15) for the current CDC guidelines on conducting a contact investigation. Always feel free to consult with the TB Program, OHA for technical assistance or advice on conducting a contact investigation.*

**Contact Investigation Data Entry comprises the following types of information in the Contacts Tab:**

- ✓ Case Infectiousness Information
- ✓ Data Submission Dates
- ✓ Contact Demographics
- ✓ Contact Risks
- ✓ Contact Medical Evaluation
- ✓ Contact Treatment and Final Status

*Please note that all screenshots contain fictitious data*

## CONTACTS TAB: Layout

The Contacts tab has four distinct areas:

- ✓ An administrative area (“Date Submitted”)
- ✓ A case-specific area (“Case Information” and “Infectious Period”)
- ✓ A clickable list of contacts
- ✓ A contact-specific detail screen with seven tabs.

The screenshot shows the CONTACTS interface. At the top, there are 'Import' and 'Export' buttons. Below is the 'Case Information' section with a 'Source Case Investigation?' checkbox and a 'Date Submitted' section with 'Initial', 'Update', and 'Final' date pickers. A 'Contact Inv Need' dropdown is set to 'High (sputum-smear pos and/or cavitary or laryngeal)'. The 'Infectious Period' section has 'Start' and 'End' date pickers, with 'End' highlighted in yellow. Below this is a 'None Elicited' checkbox and a 'Contact List' section with 'Summary' and 'Done' buttons. A table lists contacts: 'Kent, Clark' (Age 67, Sex M) and 'Oregon, Sandy' (Age 6, Sex F). The bottom section shows a detailed view for 'Kent, Clark' with tabs for Demographics, Contact Risks, Evaluation, Treatment / Final Status, Notes, Links, and Docs. The Demographics tab is active, showing fields for Name, Address, DOB, Age, Sex, Race, Hispanic, Birth Country, Date of Entry, Last Exposed, and Local Epi. A 'Transfer Status' indicator shows 'Complete 1/23/18 4:17p'.

### Submission Dates

#### **Initial Data:**

Enter initial data within 4 weeks of case report and after first round screening (<8 week TST/IGRA). Document initial data entry in the Date Submitted field.

The diagram shows the 'Date Submitted' section with three rows: 'Initial', 'Update', and 'Final'. Each row has a text input field and a calendar icon button to the right.

#### **Follow-up Data:**

Enter follow-up data within 4 months of case report, after evaluation is complete for all contacts. Document follow-up data entry in the Date Submitted field.

#### **Final Data:**

Enter final data after all contacts who started treatment for LTBI have completed treatment or have stopped treatment for other reasons. Document final data entry in the Date Submitted field after all contacts have been fully evaluated and finished treatment, as applicable.

**Case Specific Information:  
Contact Investigation Need**

The State TB Epidemiologist will review each case of active TB and assign a Contact Investigation Need level (CI Need). This information is located at the top of the Contacts tab on the Case record in Orpheus.

Priority level for a contact investigation is assigned on the basis of disease characteristics and lab test results. Contact investigation is required for any potentially infectious case.

- High: Case is sputum-smear positive and/or has radiologically confirmed cavitory disease and/or laryngeal disease. Contact investigations must be initiated within 72 hours in these cases.
- Medium: Case has sputum-smear negative, culture positive pulmonary and/or laryngeal disease. Contact investigations must be initiated within 72 hours.
- Low: Case has sputum-smear negative, culture negative pulmonary or pleural disease. A contact investigation is recommended. If resources do not allow, please notify TB Program, OHA.
- None: All others, pulmonary involvement ruled out. Contact investigation is not indicated.

**Case Specific Information:  
Infectious Period**

An estimate of the infectious period start date and end date is required.

***Infectious Period Start Date***

A conservative method to estimate the start date is to use the date three months prior to either the onset of symptoms or the first positive finding consistent with TB disease, whichever is first. Positive findings

consistent with TB include, but are not limited to: positive AFB smear, positive NAAT, positive culture for MTB, abnormal CXR consistent with TB, and initiation of treatment for TB.

Infectious Period	
Start	<input type="text"/>
End	<input type="text"/>

***Infectious Period End Date***

The end date can be determined as the date on which the patient

- has been on 4 drug TB treatment given by DOT for a minimum of 5 days and :
- has 3 consecutive AFB sputum-smear negative or equivocal specimens collected a minimum of 8 hours apart OR has a negative culture result.

*Note: this end date is for the purposes of contact investigations only; clinical decisions for removing patients from isolation may differ from the above.*

For more information on estimating the infectious period, refer to guidance located at <https://www.cdc.gov/tb/education/ssmodules/pdfs/Module8.pdf> and <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5415a1.htm>.

**Case Specific  
Information: No  
Contacts**

If no contacts were identified, complete this field to document the reason.

- No contacts identified despite effort to do so
- Contact follow-up was not done
- Contacts the same as for another case. Choose this option only if all the contacts for this case are the same as those for another case. In the Notes tab, identify the Orpheus Case ID of the related case.

**Checkbox: No  
Contacts**

Check this box if the case could not or would not identify any contacts for the contact investigation.

## CONTACTS TAB: Adding Contacts

- ✓ Contacts can be entered into Orpheus in two ways. For smaller contact investigations, individual contacts can be entered directly. To save time in larger contact investigations, the Contact Investigation Upload Form may be used. This is a formatted Excel spreadsheet that can be uploaded to Orpheus to auto-populate contact records. For more information about this option, contact the TB Epidemiologist at 971-673-0160.

**Adding a  
Contact**

A contact is a person whom the health department believes had significant exposure and for whom identifying/contacting information is available.

Add a contact by clicking  Contact above the contact list.

In the next window, enter all known demographic information and click “Create Contact.”

Orpheus will search all person records and display a list of possible name and birthdate matches. If a match appears, click “Link this Contact”. If no match appears, click “Ignore Match, Create New Person”. The new contact now appears in the Contact List.

## CONTACTS TAB: Contact Demographics

### Contact Address

Clicking the Address field pulls up an Address card. If the contact shares a residence with the case, click “Copy Case Address” to auto-populate the case’s residence address into the Contact record. Otherwise, enter all known address information and Save Changes.

### Age & Sex

Enter the Date of Birth, age and sex of the contact if not already filled.

DOB: 3/4/1956
Age: 62
Sex: F

**Birth Country &  
Date of Entry**

Birth Country and Date of Entry are essential risk factors and must be completed if possible.

Birth Country:
Date of Entry:
Last Exposed:

**Race & Ethnicity**

Enter Race and Ethnicity from the dropdown choices. Do not overwrite dropdown choices.

Race:
Hispanic:

**Date of Last  
Exposure**

Date of Last Exposure is important for timing of the first and second round tests. If exposure is ongoing, as for a household member, indicate by checking the box.

Date Last Exposed	<input type="text"/>	
Ongoing Exposure	<input type="checkbox"/>	

## CONTACTS TAB: Contact Risks

### Risk Level

Contact Risk is divided into two categories indicating high or low risk of infection for the contact. Level of risk relates directly to the contact's exposure to the case and the individual contact's medical conditions or other risks.

“High Risk of Infection” usually indicates the contact has either a significant exposure to the case or a medical risk that increases the contact's chances of becoming sick with TB after infection.

For example, if a contact is a member of the case's household, in most situations this indicates a great deal of direct exposure to the case and the contact's risk of infection would be high. Likewise, while an HIV-positive contact may have had less exposure to the case than a household contact, the fact that the contact is HIV-positive means the contact's personal risk of developing TB disease is high.

- ✓ *Contacts assigned to the “High Risk of Infection” category should be prioritized in contact follow-up. Note: Contacts initially classified as “Low” may be moved into the “High” group as the investigation progresses or expands. This is likely to occur when the case is highly infectious and you suspect lower levels of exposure are causing infection (evidence of >10% latent infection rate among contacts tested, or evidence of secondary active cases).*

Select low-risk or high-risk for infection based on exposure type.

The screenshot shows a form with two main sections: "High Risk" and "Low Risk".

**High Risk**

- Household
- Age < 5
- HIV
- CXR consistent w/inactive TB
- Congregate Setting
- Exceeds Exp Limits
- Other Medical Risk
- Other:

**Low Risk**

- No Exposure
- Other Low:

Household: Contact lives in the same residence as the case.

Age<5: Contact is <5 years old. After infection, TB disease is more likely to occur in younger children. Contacts <5 years of age should be started on window treatment after a chest x-ray is obtained.

HIV/AIDS: Contact is HIV positive or has AIDS. Consider starting contacts with HIV/AIDS on window treatment or completing a full course of treatment for LTBI. Untreated HIV infection results in the progression of TB infection to TB disease more frequently and rapidly than any other known factor.

CXR c/w Inactive TB: Fibrosis on a CXR may indicate prior or current TB disease. Contacts with CXRs indicating healed primary TB (e.g. a calcified pulmonary nodule) are not at higher risk for later developing active TB disease.

Note: The activity of TB CANNOT be determined from a single CXR, and unless there are previous CXRs showing the abnormality has not changed, it is recommended sputum be sent for examination to assess the possibility of active TB disease. Once active TB disease is excluded by sputum culture, these patients are high priority for treatment for LTBI.

Congregate setting: Exposure to the case occurred in a congregate setting, either occupational or residential (e.g. high school, correctional facility, homeless shelter, nursing home, workplace). If you believe that the contacts in a congregate setting fall into the category of “Low Risk of Infection”, please check the box “Other Low Risk” in the next column and write the setting in the space provided. Please consult with the State TB Control Program for assistance in determining if contacts are at high or low risk of infection if you have any questions. The State TB Control Program is available for onsite and/or technical assistance with all investigations in congregate settings.

Exceeds exposure limits: Contact is an otherwise healthy individual age  $\geq 5$  with exposure to the case that exceeds exposure limits (**i.e., you believe the risk is high enough that the contact’s level of exposure could result in infection**). Examples of exceeds exposure limits might include a close friend, a coworker that shares an office with the case, daily carpool member, etc.

The North Carolina TB Control Program Manual (<http://epi.publichealth.nc.gov/cd/lhds/manuals/tb/toc.html>) specifies exposure limits to assist in determining if a contact “exceeds environmental limits”. These limits are provided below should you wish to use them in your contact investigation. **A contact is not required to meet the limits below, these are for guidance only.**

- ≥ 4 cumulative hours in small, poorly ventilated space such as a car or enclosed room
- ≥ 8 cumulative hours in small well-ventilated space such as an apartment
- ≥ 12 cumulative hours in a large space such as a classroom or house
- ≥ 50 cumulative hours in large open area such as an auditorium or church

Other medical risk factor: Contact has a significant medical risk (other than HIV/AIDS). Examples:

- Those on immunosuppressive agents, including multiple cancer chemotherapy agents, antirejection drugs for transplants, TNF-alpha antagonists
- Someone receiving >15 mg of prednisone or its equivalent for >4 weeks
- Those with silicosis, uncontrolled diabetes mellitus, gastrectomy or jejunioileal bypass surgery, etc.

All patients taking prednisone or a TNF-alpha antagonist inhibitor (Enbrel, Remicade, Humira) should be treated during the window period. Consider starting all other contacts with significant medical risk(s) on treatment during the window period.

Other: Check this box if you believe the contact has a risk factor that contributes to their high risk of infection and progression to TB disease that is not listed above. Write in the risk factor in the space provided.

No Risk: Contact has no known risk factors, i.e., no actual exposure to the case.

Other Low Risk: Contact has limited exposure to the case, and you believe the risk of infection is truly low. Please note the exposure setting in the space provided. An example might be contacts from a school investigation (congregate setting) with little or no exposure to the case, and no other medical risks, that were tested as part of the investigation. Please feel free to consult with the State TB Control Program for assistance in determining if a contact's risk of infection is high or low.

## CONTACTS TAB: Contact Evaluation

### Symptomatic

Check “Symptomatic” if contact is showing signs and symptoms of TB such as cough, fever, night sweats, hemoptysis, weight loss, etc. If the contact is symptomatic, work up for TB disease.

Symptomatic?

### History of Prior TB or LTBI

If the contact has a history of TB or LTBI and you believe

Prior Positive TST/QFT?   
Prior Treatment (TB/LTBI)?   
Eval Complete

Prior Test/Treatment Notes

adequate prior treatment was completed for TB disease or LTBI, mark the box for “Prior Tx”. In absence of a documented course of therapy, some questions to ask the patient to assess whether treatment was adequate include:

- Where were you treated?
- What drugs did you receive?
- How many different drugs? How many pills each day? What size and color were the pills/capsules?
- How long were you on treatment?
- Did you take medications daily? Every pill?
- Did you miss medication sometimes? How often?
- Did health care workers observe you taking your medications?

✓ *Note: contacts with prior TST/QFT positive and/or prior treatment should, at a minimum, be screened for symptoms. A chest x-ray is recommended for contacts with medical risks or symptoms, or if the case is highly infectious (i.e., in an outbreak situation). Consider offering LTBI to prior positives who have not completed therapy.*

✓ *Note: The “New LTBI” and “Eval Complete” boxes will auto-populate according to the values entered in the evaluation tab.*

Eval Complete

New LTBI

**1st Round Test (<8 week test)**

Enter the results of the first round TST or IGRA. Tests done less than 8 weeks after last known exposure should be entered in this section. Tests administered more than 8 weeks after last exposure should be entered in the 2<sup>nd</sup> Round Test box, below.

**1st Round (<8 week test)**

TST

Date  

mm

QFT/T Spot

Date  

Result

**2nd Round Test (>8 week test)**

Enter the results of the second round TST or IGRA. A follow-up test done 8 or more weeks after a first round test should be entered here. Information should also be entered here if only one test was done and it was administered more than 8 weeks after last exposure to the case.

**2nd Round (>8 week test)**

TST

Date  

mm

QFT/T Spot

Date  

Result

**Chest X-ray**

If a chest X-ray is completed, enter date of exam and results here.

**Chest X-ray**

Date  

Result

CXR Facility

# CONTACTS TAB: Treatment/Final Status

- ✓ Complete for all contacts for whom LTBI treatment has been initiated. This may include persons with newly diagnosed LTBI, window treatment, prior positives, and immunocompromised persons being treated with a full course of preventive therapy (regardless of TST/QFT result).

**Treatment Start Date** Enter date treatment for LTBI started

<b>Treatment Start:</b>	<input type="text"/>	
<b>Treatment Stop:</b>	<input type="text"/>	
<b>Treatment Regimen:</b>	<input type="text"/>	
<b>Other Regimen:</b>	<input type="text"/>	

**Treatment Stop Date** Enter date treatment for LTBI ended

**Treatment Regimen** Choose the treatment regimen from the drop-down options. Do not overwrite options. Choose from the following options:

- INH daily 6 months
- INH daily 9 months
- INH biweekly DOT 6 months
- INH biweekly DOT 9 months
- RIF daily 4 months
- INH+Rifapentine 12 weeks
- Window Prophylaxis
- Other (specify)

If the treatment regimen is not listed, choose “Other” and describe as free text in “Other Regimen”.

**Final Status** Choose the final status of the contact after completing evaluation and/treatment if indicated. Choose from the dropdown options. Do not overwrite dropdown options.

<b>Final Status</b>	<input type="text"/>
---------------------	----------------------

- 1- Active TB Diagnosed
- 2- Died
- 3- Moved

- ✓ If contact moved out of the jurisdiction, please submit an “Interjurisdictional Transfer Notification” located at: [http://www.tbcontrollers.org/docs/resources/IJN\\_Form\\_May2015.pdf](http://www.tbcontrollers.org/docs/resources/IJN_Form_May2015.pdf)

- 4- Refused Treatment
- 5- Lost to follow-up
- 6- Provider decision (to stop or not start LTBI tx)– toxicity
- 7- Provider decision (to stop or not start LTBI tx)– other
- 8- Refused evaluation
- 9- Completed LTBI treatment

**Treatment or other comments**

Use this area to enter any contact-specific details or complications of treatment, details about incomplete evaluations, explanation for Final Status 7- Provider decision: other, etc.

Treatment comments or other contact information

## CONTACTS TAB: Notes

- ✓ Use the Notes tab to create notes specific to a contact. Information saved in Notes might include details about evaluation findings, documentation of attempts to locate or follow-up with contact, or reminders for subsequent testing. Do not put contact-specific notes in the Case notes.



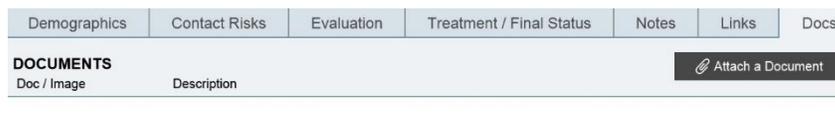
The screenshot shows a navigation bar with tabs: Demographics, Contact Risks, Evaluation, Treatment / Final Status, and Note. Below the tabs is a section labeled 'NOTES' with a dropdown menu containing 'Add a QuickNote...' and a plus icon in a box. Below this is a large, empty light blue rectangular area for writing notes.

## CONTACTS TAB: Links

- ✓ The links tab displays other Orpheus case records or contact records for the current contact.

## CONTACTS TAB: Docs

- ✓ The Docs tab is a convenient location to upload and store documents related to the specific contact. Documents might include chart notes or radiology reports.



The screenshot shows a navigation bar with tabs: Demographics, Contact Risks, Evaluation, Treatment / Final Status, Notes, Links, and Docs. Below the tabs is a section labeled 'DOCUMENTS' with a table header: 'Doc / Image' and 'Description'. To the right of the header is a dark button with a plus icon and the text 'Attach a Document'.