

**The EDN Tuberculosis Follow-Up Worksheet for Newly-Arrived Persons with Overseas Tuberculosis Classifications**

<b>A. Demographic</b>			
<b>A1. Name (Last, First, Middle):</b>	<b>A2. Alien #:</b>	<b>A3. Visa type:</b>	<b>A4. Initial U.S. entry date:</b>
A5. Age:	A6. Sex:	A7. DOB: _____/_____/_____	A8. TB Class Based on <i>Technical Instructions for Panel Physicians</i> :
A9. Country of examination:		A10. Country of birth:	
A11a. Name in care of:		A12a. Sponsor agency name:	
A11b. Phone number:		A12b. Phone number:	
A11c. Address:		A12c. Address:	
<b>B. Jurisdictional Information</b>			
B1. Arrival jurisdiction:		B2. Current jurisdiction:	
<b>C. U.S. Evaluation</b>			
C1. Date of first U.S. test or provider/clinic visit: _____/_____/_____			
<b>Mantoux Tuberculin Skin Test (TST) in U.S.</b>	<b>Interferon-Gamma Release Assay (IGRA) in U.S.</b>		
<p>C2a. Was a TST administered in the U.S.?  <input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Unknown</p> <p><i>If YES</i>, C2b. TST placement date: _____/_____/_____</p> <p><input type="checkbox"/> Placement date known</p> <p>C2c. TST mm: _____ <input type="checkbox"/> Unknown</p> <p>C2d. TST interpretation:</p> <p><input type="checkbox"/> Positive   <input type="checkbox"/> Negative  <input type="checkbox"/> Unknown</p> <p>C2e. History of Previous Positive TST:</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Unknown</p>	<p>C3a. Was IGRA performed?   <input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Unknown</p> <p><i>If YES</i>, C3b. Date collected: _____/_____/_____   <input type="checkbox"/> Date unknown</p> <p>_____ IU/Spots</p> <p>C3c. IGRA brand:</p> <p><input type="checkbox"/> QuantiFERON®   <input type="checkbox"/> T-SPOT</p> <p><input type="checkbox"/> Other (specify): _____</p> <p>C3d. Result:   <input type="checkbox"/> Positive   <input type="checkbox"/> Negative   <input type="checkbox"/> Indeterminate,  Borderline, or  Equivocal</p> <p><input type="checkbox"/> Invalid   <input type="checkbox"/> Unknown</p> <p>C3e. History of previous positive IGRA:</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Unknown</p>		
<b>U.S. Review of Pre-Immigration CXR</b>	<b>U.S. Domestic CXR</b>	<b>Comparison</b>	
<p>C4. Pre-immigration CXR available?  <input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Unknown</p>	<p>C6a. U.S. domestic CXR done?  <input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Unknown</p> <p><i>If YES</i>, C6b. Date of U.S. CXR: _____/_____/_____</p>	<p>C8. U.S. domestic CXR comparison to pre-immigration CXR:</p> <p><input type="checkbox"/> Stable  <input type="checkbox"/> Worsening  <input type="checkbox"/> Improving  <input type="checkbox"/> Unknown</p>	
<p>C5. U.S. interpretation of pre-immigration CXR:</p> <p><input type="checkbox"/> Normal (Negative for TB)  <input type="checkbox"/> Abnormal  <input type="checkbox"/> Suggestive of TB  <input type="checkbox"/> Non-TB Condition  <input type="checkbox"/> Poor Quality/Not Interpretable  <input type="checkbox"/> Unknown</p>	<p>C7. Interpretation of U.S. CXR:</p> <p><input type="checkbox"/> Normal (Negative for TB)  <input type="checkbox"/> Abnormal  <input type="checkbox"/> Suggestive of TB  <input type="checkbox"/> Non-TB Condition  <input type="checkbox"/> Poor Quality/Not Interpretable  <input type="checkbox"/> Unknown</p>		

Public reporting burden of this collection of information is estimated to average 30 minutes per individual, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

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Alien # \_\_\_\_\_

**U.S. Review of Pre-Immigration Treatment**

C9a. Completed treatment pre-immigration?  Yes  No  
 Unknown

If **YES**, C9b.  Treated for TB disease  Treated for LTBI  
 Treated, but unknown if TB disease or LTBI

If **Treated for TB disease**,

Treatment completed **prior** to panel physician examination  
 Treatment completed **after** panel physician diagnosis (DS 3030)

At designated DOT site  
 At non-designated DOT site  
 Other, specify: \_\_\_\_\_

C9c. Treatment start date: \_\_\_/\_\_\_/\_\_\_  Start date unknown

C9d. Treatment end date: \_\_\_/\_\_\_/\_\_\_  End date unknown

C9e. Report of treatment administered prior to panel physician examination:

Treatment documented on overseas medical history form (DS 3026)  
 Documented on DS forms & patient reported at panel physician examination  
 After U.S. arrival only, patient verbally reported treatment completion  
 Unknown

C9f. Standard TB treatment regimen was administered?  
 Yes  No  Unable to verify

C10a. Arrived to the U.S. on treatment?  
 Yes  No  
 Unknown

If **YES**, C10b.  Treated for TB disease  Treated for LTBI

C10c. Start date: \_\_\_/\_\_\_/\_\_\_  Start date unknown

C11a: Pre-Immigration treatment concerns?  
 Yes  No

If **YES**, C11b. *Select all that apply:*

Treatment duration too short  
 Incorrect treatment regimen  
 Inadequate information provided  
 Lack of adequate diagnostics  
 Unknown DOT/adherence status  
 Other, please specify: \_\_\_\_\_

**C12. U.S. Microscopy/Bacteriology\*** Sputa collected in U.S.?  Yes  No *\*Covers all results regardless of sputa collection method.*

#	Date Collected	AFB Smear		Sputum Culture		Drug Susceptibility Testing	
1	___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> NTM	<input type="checkbox"/> MTB Complex	<input type="checkbox"/> MDR-TB	<input type="checkbox"/> Mono-RIF
		<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown	<input type="checkbox"/> Contaminated	<input type="checkbox"/> Negative	<input type="checkbox"/> Mono-INH	<input type="checkbox"/> Other DR
				<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown	<input type="checkbox"/> No DR	<input type="checkbox"/> Not Done
2	___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> NTM	<input type="checkbox"/> MTB Complex	<input type="checkbox"/> MDR-TB	<input type="checkbox"/> Mono-RIF
		<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown	<input type="checkbox"/> Contaminated	<input type="checkbox"/> Negative	<input type="checkbox"/> Mono-INH	<input type="checkbox"/> Other DR
				<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown	<input type="checkbox"/> No DR	<input type="checkbox"/> Not Done
3	___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> NTM	<input type="checkbox"/> MTB Complex	<input type="checkbox"/> MDR-TB	<input type="checkbox"/> Mono-RIF
		<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown	<input type="checkbox"/> Contaminated	<input type="checkbox"/> Negative	<input type="checkbox"/> Mono-INH	<input type="checkbox"/> Other DR
				<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown	<input type="checkbox"/> No DR	<input type="checkbox"/> Not Done

**D. Evaluation Disposition in U.S.**

D1a. Evaluation disposition date in U.S.: \_\_\_/\_\_\_/\_\_\_

D1b. State/jurisdiction of evaluation disposition in U.S.: \_\_\_\_\_

D2a. Evaluation disposition in U.S.:

Completed evaluation  Initiated Evaluation / Not completed  Did not initiate evaluation

D2b. *If evaluation was completed, was treatment recommended?*  
 Yes  No

LTBI  
 Active TB

D2c. *If evaluation was NOT completed, why not? Select all that apply.*

Not Located  Moved within U.S., transferred to: \_\_\_\_\_ State/jurisdiction  
 Lost to Follow-Up  Moved outside U.S.  
 Refused Evaluation  Died  
 Unknown  Other, specify: \_\_\_\_\_

D3. Diagnosis

Class 0 - No TB exposure, not infected or Class 1 - TB exposure, no evidence of infection  
 Class 2 - TB infection, no disease  Class 3 - TB, TB disease  
 Class 4 - TB, inactive disease  Pulmonary  Extra-pulmonary  Both sites

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**Alien #**

D4. If diagnosed with TB disease:

State Case Number:     \_\_\_\_\_  
 Year State RVCT # / TBLISS #

RVCT # unknown\*  RVCT Reported\*

TBLISS # unknown\*  TBLISS Reported\*

City/County Case Number:     \_\_\_\_\_  
 Year State RVCT # / TBLISS #

\*Note: Either the RVCT or TBLISS number may be reported.

**E. U.S. Treatment for TB Disease or TB Infection**

E1a. U.S. treatment initiated:  Yes  No  Unknown

E1b. If **NO**, specify the reason. Select all that apply:

- Patient declined against medical advice
- Lost to follow-up
- Moved within U.S., transferred to: \_\_\_\_\_  
State/jurisdiction
- Died
- Moved outside the U.S.
- Prior treatment completed (year: \_\_\_\_\_)
- Currently on treatment
- Treatment not offered based on local clinic guidelines
- Unknown
- Contraindication for treatment
- Other, specify: \_\_\_\_\_

E1c. If **YES**:  Treated for TB disease  Treated for LTBI

E2. Treatment start date: \_\_\_\_/\_\_\_\_/\_\_\_\_ E3. State/jurisdiction of treatment in U.S.: \_\_\_\_\_

E4. Specify initial LTBI regimen:

- Isoniazid (9 months; 9H)
- Isoniazid (6 months; 6H)
- Isoniazid/Rifapentine (3 months; 3HP)
- Isoniazid/Rifampin (INH+RIF; 4 months)
- Rifampin (4 months; 4R)
- Isoniazid/Rifampin/Ethambutol/Pyrazinamide (RIPE; 2 months; suspected TB disease)
- Unknown
- Other, specify: \_\_\_\_\_

E5a. U.S. treatment completed:  Yes  No  Unknown

If **NO**, E5b. Specify the reason. Select all that apply:

- Patient declined against medical advice
- Lost to follow-up
- Moved within U.S., transferred to: \_\_\_\_\_  
State/jurisdiction
- Died
- Moved outside the U.S.
- Unknown
- Dying (treatment stopped because of imminent death, regardless of cause of death)
- Adverse effect
- Other, specify: \_\_\_\_\_
- Provider decision
- Not TB disease
- Developed TB [For patient diagnosed with LTBI]
- Pregnancy [For patient diagnosed with LTBI]

E6. Date therapy stopped: \_\_\_\_/\_\_\_\_/\_\_\_\_

Specify reason therapy stopped: \_\_\_\_\_

**F. Evaluation Site Information**

Provider's Name:  
 Clinic Name:  
 Telephone Number:

**G. Treatment Site Information**

Provider's Name:  
 Clinic Name:  
 Telephone Number:  
 Same as evaluation site information

**H. Comments**

\_\_\_\_\_