Connecticut Department of Public Health
Tuberculosis Control Program
410 Capitol Avenue, MS #11TUB
P.O. Box 340308
Hartford, CT 06134-0308
Phone: 860-509-7722 Fax: 860-509-7743

Tuberculosis Surveillance Report Form

Complete for ALL TB Disease and Latent TB Infection

PATIENT INFORMATION

Patient Name – Last, First, Middle	Sex at Birth	Date of Birth	Best Phone Number	Alternate Phone
	☐ Male ☐ Female ☐ Other: _____	____|____|____ MM DD YYYY		

Street Address	City	State	Zip	Ever Served in U.S. Military
				☐ Yes ☐ No

Race (select one or more)
☐ American Indian/Alaska Native ☐ Asian (specify): _____ ☐ Black or African American
☐ White ☐ Native Hawaiian or Other Pacific Islander (specify): _____

Ethnicity (select one)
☐ Hispanic or Latino/a
☐ Not Hispanic or Latino/a

Preferred Language: _____

Country of Birth

Month-Year Arrived in U.S.

Country of Usual Residence: _____
Country of Birth for Guardian(s) of TB patients <15 years old: _____
Country of Previous Residence for more than 60 days: _____
Travel for more than 30 days: _____

Patient's Insurance Status
☐ Uninsured ☐ Private
☐ Medicare ☐ Other (specify): _____
☐ Medicaid
☐ TB Medicaid

Status at Diagnosis
☐ Alive ☐ Dead
Date of Death: ____\|____\|____ MM DD YYYY

Current Occupation :

Ever worked in:
☐ Healthcare ☐ Migrant/Seasonal
☐ Correctional facility ☐ None of the above

Most recent employer/school name and address::

SCREENING

Tuberculin (Mantoux) Skin Test (TST):
Date Read: ____\|____\|____ MM DD YYYY
☐ Positive: _____mm
☐ Negative
☐ Not done

Interferon Gamma Release Assay for Mycobacterium Tuberculosis (IGRA):
Date Collected: ____\|____\|____ MM DD YYYY
☐ Positive ☐ Indeterminate
☐ Negative ☐ Not Done
☐ Borderline (T Spot Only)
Test Type:
☐ QuantiFERON ☐ T-Spot.TB

History of Negative TST?	Date of Last Negative TST?	History of Latent TB Infection or TB Disease?	Smoking History
☐ Yes ☐ No	____|____ MM YYYY	☐ Disease Year: _____ ☐ Infection Year: _____ ☐ None	☐ Current ☐ Former ☐ Never

IMAGING – PLEASE ATTACH COPIES OF ALL IMAGING REPORTS

Initial Chest Radiograph (CXR)
Date: ____\|____\|____ MM DD YYYY
☐ Normal
☐ Abnormal
☐ Not Done

If ABNORMAL:
Evidence of a cavity ☐ Yes ☐No
Evidence of miliary TB ☐ Yes ☐No

Other Imaging Study Select one: ☐ CXR ☐ CT Scan ☐ MRI
Date: ____\|____\|____ MM DD YYYY
☐ Normal
☐ Abnormal
☐ Not Done

If ABNORMAL:
Evidence of a cavity ☐ Yes ☐ No
Evidence of miliary TB ☐ Yes ☐ No

BACTERIOLOGY RESULTS – PLEASE ATTACH COPIES OF ALL RESULTS

#	Date Collected	Specimen Type	Smear	Nucleic Acid Amplification Test	Culture
1	____|____|____ MM DD YYYY	☐ Sputum ☐ Fluid (specify):_____ ☐ Tissue (specify): _____	☐ Positive ☐ Negative ☐ Pending	☐ Positive ☐ Negative ☐ Indeterminate ☐ Not Done Rifampin resistance detected? ☐ Yes ☐ No ☐ Not Done	☐ MTB + ☐ MTB - ☐ Pending ☐ Non-TB sp.
2	____|____|____ MM DD YYYY	☐ Sputum ☐ Fluid (specify):_____ ☐ Tissue (specify): _____	☐ Positive ☐ Negative ☐ Pending	☐ Positive ☐ Negative ☐ Indeterminate ☐ Not Done Rifampin resistance detected? ☐ Yes ☐ No ☐ Not Done	☐ MTB + ☐ MTB - ☐ Pending ☐ Non-TB sp.
3	____|____|____ MM DD YYYY	☐ Sputum ☐ Fluid (specify):_____ ☐ Tissue (specify): _____	☐ Positive ☐ Negative ☐ Pending	☐ Positive ☐ Negative ☐ Indeterminate ☐ Not Done Rifampin resistance detected? ☐ Yes ☐ No ☐ Not Done	☐ MTB + ☐ MTB - ☐ Pending ☐ Non-TB sp.

DIAGNOSIS & EVALUATION

Diagnosis
☐ TB Disease (specify site): _____
☐ Latent TB Infection

Reason for Evaluation
☐ TB symptoms (onset date) ____\|____\|____ MM DD YYYY
☐ Contact investigation ☐ Screening
☐ Immigration or B1/B2 evaluation ☐ Other: _____

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Patient Name: _____
Last Middle First

HIV / HEPATITIS TESTING – ATTACH COPIES OF POSITVE RESULTS

HIV Test Date
_____|_____|_____
MM DD YYYY

HIV Test Results
☐ Negative ☐ Results pending
☐ Positive ☐ Refused
☐ Indeterminate

☐ CD4 # _____ Test Date: _____

Hepatitis Test Date
_____|_____|_____
MM DD YYYY

Tests performed and results :
☐ HBV ☐ Neg ☐ Pos ☐ Not done
☐ HCV ☐ Neg ☐ Pos ☐ Not done

RISK FACTORS

Resident of Long Term Care Facility at the time of diagnosis? ☐ Yes, specify facility name: _____ ☐ No

Resident of Correctional Facility at the time of diagnosis? ☐ Yes, specify facility: _____ ☐ No
Resident of Correctional Facility at any time? ☐ Yes ☐ No

Within past year has the patient:

☐ Been homeless?	☐ Yes	If Yes,	☐ Currently	☐ Within the last year	☐ Ever, when: _____	☐ No
☐ Used injection drugs?	☐ Yes	If Yes,	☐ Currently	☐ Within the last year	☐ Ever, when: _____	☐ No
☐ Used other drugs?	☐ Yes	If Yes,	☐ Currently	☐ Within the last year	☐ Ever, when: _____	☐ No
☐ Used excess alcohol?	☐ Yes	If Yes,	☐ Currently	☐ Within the last year	☐ Ever, when: _____	☐ No

ADDITIONAL TB RISK FACTORS / MEDICAL CONDITIONS

☐ Contact of infectious TB patient (<=2 years) If known case, give name of source case: _____
☐ Incomplete LTBI treatment ☐ Diabetes mellitus: A1C _____ % or fasting blood glucose _____ Date of test: _____
☐ Pregnant - Due date: _____|_____|_____ ☐ End stage renal disease: ☐ Immunosuppression (not HIV/AIDS), specify:_____
☐ Tumor necrosis factor-alpha (TNF-α) antagonist therapy. ☐ Post-organ transplant: ☐ Cancer, specify: _____ ☐ None

TREATMENT

Initial treatment regimen – Please complete for all medications, include dosage per mg.

Start Date:
_____|_____|_____
MM DD YYYY

Expected Duration:
_____
# of months

☐ Isoniazid……..	_____	☐ Rifapentine……..	_____
☐ Rifampin …….....	_____	☐ Rifabutin…….	_____
☐ Ethambutol ……..	_____	☐ Other drug/dose	_____
☐ Pyrazinamide …..	_____	☐ Other drug/dose	_____
☐ Pyridoxine (B6)…	_____	☐ Other drug/dose	_____

Please specify NON-TB medications, include dosage per mg or attach medication list.

_____
_____
_____
_____

Directly Observed Therapy Performed by:
☐ Local Health Dept. ☐ VNA ☐ DPH
☐ Other, specify: _____

Preferred/Regular Pharmacy:
Name: _____
Address: _____

Discharge/Treatment Plan Completed?
☐ Yes ☐ No
Copies sent to: ☐ DPH ☐ Local Health Dept.

PROVIDER INFORMATION

Was patient hospitalized?	Medical Record Number	Date Admitted	Date Discharged
☐ Yes **If yes, discharge plan required** ☐ No		_____|_____|_____ MM DD YYYY	_____|_____|_____ MM DD YYYY

Admitting Hospital	Phone
Attending Physician	Phone
Discharge Planner/Care Coordinator Contact Information	Phone
Floor/Unit	Fax

Person Completing This Report	Phone	Date of This Report
		_____|_____|_____ MM DD YYYY