Print Form

State of CT Department of Public Health
Tuberculosis Control Program
410 Capitol Avenue, MS #11TUB
P.O. Box 340308
Hartford, CT 06134-0308

# TUBERCULOSIS SURVEILLANCE REPORT
## TB-86 FORM – PAGE 1
### COMPLETE FOR ALL TB CASES and TB CASE SUSPECTS

Voice: (860) 509-7722 Fax:: (860) 509-7743

CASE NUMBER: *(For Office Use Only)*

| PATIENT'S NAME: (LAST) | (FIRST) | SEX AT BIRTH: ☐ M ☐ F | DATE OF BIRTH: MM DD YYYY |
|---|---|---|---|
| STREET ADDRESS: | CITY: | STATE: | ZIP: |
| HOME TELEPHONE: | | | |

RACE (SELECT ONE OR MORE) :
- ☐ AMERICAN INDIAN/ALASKAN NATIVE
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ ASIAN: _____ SPECIFY
- ☐ WHITE
- ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER: _____ SPECIFY

ETHNICITY: (SELECT ONE)
- ☐ HISPANIC OR LATINO
- ☐ NOT HISPANIC OR LATINO

ALTERNATE TELEPHONE:

SSN:

COUNTRY OF BIRTH:

MONTH-YEAR ARRIVED IN U.S.:

IMMIGRATION STATUS AT FIRST ENTRY TO THE U.S.:
- ☐ NOT APPLICABLE/U.S. BORN
  - "U.S.-BORN" (OR BORN ABROAD TO A PARENT WHO WAS U.S. CITIZEN)
  - BORN IN 1 OF THE U.S. TERRITORIES, U.S. ISLAND AREAS, OR U.S. OUTLYING AREAS)
- ☐ STUDENT VISA
- ☐ FAMILY/FIANCE VISA
- ☐ OTHER IMMIGRATION STATUS
- ☐ EMPLOYMENT VISA
- ☐ REFUGEE
- ☐ IMMIGRANT VISA
- ☐ TOURIST VISA
- ☐ ASYLEE OR PAROLEE
- ☐ UNKNOWN

**SPECIFY ALL SITES OF DISEASE:**

PREVIOUS TB? ☐ DISEASE ☐ INFECTION

IF YES, YEAR:

STATUS AT DIAGNOSIS: ☐ ALIVE ☐ DEAD

**IF DEAD**, WAS TB A CAUSE OF DEATH: ☐ YES ☐ NO

DATE OF DEATH: MM DD YYYY

PEDIATRIC TB PATIENTS (<15 YEARS OLD):

PATIENT LIVED OUTSIDE U.S. FOR >2 MONTHS? ☐ YES ☐ NO

IF YES, SPECIFY COUNTRIES: _____

COUNTRY OF BIRTH FOR PRIMARY GUARDIAN(S), SPECIFY COUNTRIES,:

GUARDIAN 1: _____

GUARDIAN 2: _____

## BACTERIOLOGY RESULTS

| # | DATE COLLECTED | SPECIMEN TYPE | SMEAR | NUCLEIC ACID AMPLIFICATION TEST | CULTURE |
|---|---|---|---|---|---|
| 1. | MM DD YYYY | ☐ SPUTUM ☐ FLUID _____ TYPE OF FLUID ☐ TISSUE _____ TYPE OF TISSUE | ☐ PENDING ☐ POSITIVE ☐ NEGATIVE | ☐ POSITIVE ☐ INDETERMINATE ☐ NEGATIVE ☐ NOT DONE | ☐ PENDING ☐ (+) MTB ☐ NEGATIVE ☐ ATYPICAL |
| 2. | MM DD YYYY | ☐ SPUTUM ☐ FLUID _____ TYPE OF FLUID ☐ TISSUE _____ TYPE OF TISSUE | ☐ PENDING ☐ POSITIVE ☐ NEGATIVE | ☐ POSITIVE ☐ INDETERMINATE ☐ NEGATIVE ☐ NOT DONE | ☐ PENDING ☐ (+) MTB ☐ NEGATIVE ☐ ATYPICAL |

**INITIAL CHEST RADIOGRAPH:**

DATE CXR: MM DD YYYY

- ☐ NORMAL
- ☐ ABNORMAL-CONSISTENT W/ TB DISEASE
- ☐ ABNORMAL-NOT CONSISTENT W/ TB DISEASE
- ☐ NOT DONE

FOR ABNORMAL INITIAL CHEST RADIOGRAPH:
EVIDENCE OF A CAVITY: ☐ YES ☐ NO
EVIDENCE OF MILIARY TB: ☐ YES ☐ NO

**OTHER IMAGING STUDY:** SELECT ONE: ☐ CXR ☐ CT SCAN ☐ MRI

DATE CXR OR IMAGING STUDY: MM DD YYYY

- ☐ NORMAL
- ☐ ABNORMAL-CONSISTENT W/ TB DISEASE
- ☐ ABNORMAL-NOT CONSISTENT W/ TB DISEASE
- ☐ NOT DONE

FOR ABNORMAL INITIAL CHEST RADIOGRAPH:
EVIDENCE OF A CAVITY: ☐ YES ☐ NO
EVIDENCE OF MILIARY TB: ☐ YES ☐ NO

**TUBERCULIN (MANTOUX) SKIN TEST AT TIME OF DIAGNOSIS: (SELECT ONE)**

DATE TUBERCULIN SKIN TEST PLACED: MM DD YYYY

- ☐ POSITIVE _____ MILLIMETERS OF INDURATION
- ☐ NEGATIVE
- ☐ NOT DONE

**INTERFERON GAMMA RELEASE ASSAY FOR MYCOBACTERIUM TUBERCULOSIS AT DIAGNOSIS (SELECT ONE):**

DATE COLLECTED: MM DD YYYY

- ☐ POSITIVE
- ☐ INDETERMINATE
- ☐ NEGATIVE
- ☐ NOT DONE

TEST TYPE: (SPECIFY) _____

**INITIAL TREATMENT REGIMEN - PLEASE COMPLETE FOR ALL MEDICATIONS AND DOSAGES:**

DATE THERAPY STARTED: MM DD YYYY

**EXPECTED DURATION OF TREATMENT:**

| | | | |
|---|---|---|---|
| ☐ ISONIAZID | _____ MG | ☐ OTHER | _____ MG |
| ☐ RIFAMPIN | _____ MG | ☐ OTHER | _____ MG |
| ☐ PYRAZINAMIDE | _____ MG | ☐ OTHER | _____ MG |
| ☐ ETHAMBUTOL | _____ MG | ☐ OTHER | _____ MG |
| ☐ VITAMIN B6 | _____ MG | ☐ OTHER | _____ MG |
| ☐ OTHER | _____ MG | ☐ OTHER | _____ MG |

| FACILITY/PHYSICIAN'S NAME: | ADDRESS: | | |
|---|---|---|---|
| PERSON COMPLETING THIS REPORT: | TELEPHONE: | FAX: | DATE OF THIS REPORT: MM DD YYYY |

MAIL: WHITE TO STATE HEALTH DEPARTMENT, YELLOW TO LOCAL HEALTH DEPARTMENT, PINK TO PATIENT'S FILE

State of CT Department of Public Health
Tuberculosis Control Program
410 Capitol Avenue, MS #11TUB
P.O. Box 340308
Hartford, CT 06134-0308

# TUBERCULOSIS SURVEILLANCE REPORT
## TB-86 FORM – PAGE 2
### COMPLETE FOR ALL TB CASES and TB CASE SUSPECTS

Voice: (860) 509-7722 Fax:: (860) 509-7743

CASE NUMBER: *(For Office Use Only)*

PATIENT'S NAME: (LAST) (FIRST)

PRIMARY REASON EVALUATED FOR TB: (SELECT ONE)

- ☐ TB SYMPTOMS: ONSET DATE: _____
- ☐ HEALTH CARE WORKER
- ☐ ABNORMAL CHEST RADIOGRAPH-CONSISTENT WITH TB DISEASE
- ☐ IMMIGRATION MEDICAL EXAM
- ☐ TARGETED TESTING
- ☐ INCIDENTAL LAB REPORT
- ☐ CONTACT INVESTIGATION
- ☐ EMPLOYMENT/ ADMINISTRATIVE TESTING

HIV STATUS AT TIME OF DIAGNOSIS:

- ☐ NEGATIVE
- ☐ CLIENT REFUSED
- ☐ POSITIVE
- ☐ NOT OFFERED
- ☐ INDETERMINATE
- ☐ TEST DONE, RESULTS UNKNOWN

DATE: _____

RESIDENT OF CORRECTIONAL FACILITY AT TIME OF DIAGNOSIS: ☐ YES ☐ NO

IF YES, PLEASE SPECIFY FACILITY: _____

RESIDENT OF CORRECTIONAL FACILITY AT ANY TIME: ☐ YES ☐ NO

**DIRECTLY OBSERVED THERAPY:**
**(RECOMMENDED FOR THOSE WITH SUSPECT/CONFIRMED TB DISEASE)** PERFORMED BY:

☐ LOCAL HEALTH DEPT. ☐ STATE HEALTH DEPT. ☐ VNA ☐ OTHER

**DISCHARGE/TREATMENT PLAN COMPLETED:** ☐ YES ☐ NO

COPIES SENT TO : ☐ LOCAL HEALTH DEPT ☐ STATE HEALTH DEPT

RESIDENT OF LONG TERM CARE FACILITY AT TIME OF DIAGNOSIS: ☐ YES ☐ NO

IF YES, PLEASE SPECIFY FACILITY NAME AND TYPE: _____

**WITHIN THE PAST YEAR** HAS THE PATIENT?

| | | |
|---|---|---|
| BEEN HOMELESS? | ☐ YES | ☐ NO |
| USED INJECTION DRUGS? | ☐ YES | ☐ NO |
| USED NON-INJECTION DRUGS? | ☐ YES | ☐ NO |
| USED EXCESS ALCOHOL? | ☐ YES | ☐ NO |

DOES PATIENT HAVE HEALTH INSURANCE: ☐ YES ☐ NO

PRIMARY OCCUPATION WITHIN THE PAST YEAR (SELECT ONE):

- ☐ HEALTH CARE WORKER
- ☐ CORRECTIONAL FACILITY EMPLOYEE
- ☐ MIGRANT/SEASONAL WORKER
- ☐ NOT SEEKING EMPLOYMENT (E.G. STUDENT, HOMEMAKER, DISABLED)
- ☐ OTHER OCCUPATION
- ☐ RETIRED
- ☐ UNEMPLOYED

NAME AND ADDRESS OF EMPLOYER/SCHOOL:

ADDITIONAL TB RISK FACTORS:

- ☐ CONTACT OF MDR-TB PATIENT (2 YEARS OR LESS)
- ☐ CONTACT OF INFECTIOUS TB PATIENT (2 YEARS OR LESS)

IF CONTACT TO KNOWN CASE PLEASE GIVE NAME OF SOURCE CASE: _____

- ☐ CLASS A/B TB: SPECIFY _____
- ☐ MISSED CONTACT (2 YEARS OR LESS)
- ☐ INCOMPLETE LATENT TB INFECTION THERAPY
- ☐ DIABETES MELLITUS
- ☐ END-STAGE RENAL DISEASE
- ☐ POST-ORGAN TRANSPLANTATION
- ☐ IMMUNOSUPPRESSION (NOT HIV/AIDS)
- ☐ TUMOR NECROSIS FACTOR-ALPHA (TNF-α ) ANTAGONIST THERAPY
- ☐ OTHER: SPECIFY _____
- ☐ NONE

MEDICAL PROBLEMS/COMMENTS:

## PROVIDER INFORMATION

| WAS PATIENT HOSPITALIZED? | DISCHARGE PLAN REQUIRED | CHART NUMBER: | DATE ADMITTED: | DATE DISCHARGED: |
|---|---|---|---|---|
| ☐ YES ☐ NO | | | MM DD YYYY | MM DD YYYY |

HOSPITAL: TELEPHONE:

ATTENDING PHYSICIAN: BEEPER/PAGER NO.:

PHYSICIAN FOR CONTINUING TB SUPERVISION:

FACILITY: FAX:

ADDRESS: TELEPHONE:

PERSON COMPLETING THIS REPORT: TELEPHONE: DATE OF THIS REPORT: MM DD YYYY

MAIL: WHITE TO STATE HEALTH DEPARTMENT, YELLOW TO LOCAL HEALTH DEPARTMENT, PINK TO PATIENT'S FILE