Reset Form

REPORT OF TUBERCULOSIS

State Form 14058 (R10 / 4-21)
Indiana Department of Health
THIS FORM CONTAINS CONFIDENTIAL INFORMATION PER 410 IAC 1-2.5-78.

Submit form via NBS or fax completed form to Indiana Department of Health at (317) 233-7747.
Telephone: (317) 233-7434

TB Law: Every suspected and verified case of tuberculosis disease must be reported to the local health officer or health department within twenty-four (24) hours in accordance with 410 IAC 1-2.5.

1. Patient name *(Last, First, MI)*

_____

2. Address *(number and street)* _____

City_____ ZIP code_____

County_____ Telephone (_____)_____

3. Date of birth ____-_____-_____ **4. At time of report** ☐ Alive ☐ Dead

5. Sex at birth ☐ Male ☐ Female
If female, was individual pregnant at time of evaluation? ☐ Yes ☐ No

6. Race *(Check all that apply.)*
☐ American Indian or Alaska Native ☐ Asian *(specify)* _____
☐ Black or African-American ☐ Native Hawaiian or other Pacific Islander *(specify)* _____
☐ White ☐ Other Race *(specify)* _____

7. Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

8. Born in the United States? ☐ Yes ☐ No
If "No," country of birth_____
Date arrived in the U.S. *(month, date, year)* _____--_____--_____

9. Country of usual residence

_____

10. Lived outside of the United States for >2 months uninterrupted?
☐ Yes ☐ No
If yes, list countries:_____

11. Pediatric TB patients (<15 years old)
Country of birth for primary guardian(s) *(specify)*
Guardian 1 _____
Guardian 2 _____

FOR LOCAL HEALTH DEPARTMENT USE ONLY

Date local health department notified of TB Suspect / TB Case _____
(month, day, year)

Reported by_____ Telephone _____

FOR ALL NON-LOCAL HEALTH DEPARTMENT USE ONLY

Reported by:_____

Agency:_____

Telephone: _____

Attending Physician: _____

Telephone: _____

12. Initial reason evaluated for TB disease ***(Select one.)***
☐ Contact investigation Name of case _____
☐ Screening
☐ TB symptoms
☐ Other _____

13. Previous diagnosis of TB disease and/or Latent TB Infection?

	TB Disease	Latent TB Infection
Previous diagnosis	☐ Yes ☐ No	☐ Yes ☐ No
Year of diagnosis		
Completed treatment?	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Length of treatment		

Patient Name _____

14. HIV status at time of diagnosis *(Select one.)*

Date of HIV Test *(month, day, year)* _____

☐ Positive ☐ Indeterminate ☐ Refused

☐ Negative ☐ Pending ☐ Not Offered

If HIV-Positive, was a CD4 Count test performed? ☐ Yes ☐ No

Date collected *(month, day, year)*_____Result: _____cells/mm^3

15. Was the patient diabetic at the time of evaluation? ☐ Yes ☐ No

If yes, was an A1C test performed? ☐ Yes ☐ No

Date collected *(month, day, year)* _____ Result:_____%

If yes, was a Fasting Blood Glucose Test performed? ☐ Yes ☐ No

Date collected *(month, day, year)* _____Result:_____ ml/dL

16. Current smoking or vaping of nicotine products status at time of evaluation?

☐ Current everyday smoker ☐ Current someday smoker

☐ Former smoker ☐ Never smoker

☐ Smoker, current status unknown

17. Has the patient <u>ever</u> worked as one of the following? *(Select all that apply.)*

☐ Health care worker ☐ Migrant / seasonal worker

☐ Correctional facility worker ☐ None of the above

18. What is the patient's current occupation?

☐ Health care worker ☐ Migrant / seasonal worker

☐ Correctional facility worker

☐ Other occupation (*specify*) _____

Place of employment _____

☐ Retired ☐ Unemployed

☐ Not seeking employment (e.g., student, homemaker, disabled person)

☐ Student School _____

19. Has the patient been homeless in the past twelve (12) months?

☐ Yes ☐ No

If yes, name of facility _____

19a. Has the patient <u>ever</u> been homeless? ☐ Yes ☐ No

If yes, name of facility _____

20. Was the patient a resident of a correctional facility at time of evaluation?

☐ Yes ☐ No

If yes, name of facility _____

Type of facility *(Select one.)*

☐ Local jail ☐ State prison ☐ Federal prison ☐ Juvenile correctional facility

☐ Other correctional facility

20a. Was the patient <u>ever</u> a resident of a correctional facility? ☐ Yes ☐ No

If yes, name, location, and date *(month, day, year)* of most recent incarceration:

_____

21. Was the patient a resident of a long-term care facility at time of diagnosis?

☐ Yes ☐ No

If yes, name of facility _____

Type of facility *(Select one.)*

☐ Nursing home ☐ Residential facility ☐ Alcohol or drug treatment facility

☐ Hospital-based facility ☐ Mental health residential facility

☐ Other long-term care facility

22. Additional risk factors *(select all that apply)*

☐ Contact of infectious TB patient (Two (2) years or less) _____

☐ End-stage renal disease at evaluation

☐ Heavy alcohol use in past twelve (12) months

☐ Immunocompromise (not HIV/AIDS)

☐ Injecting drug use in past twelve (12) months

☐ Noninjecting drug use in past twelve (12) months

☐ Post-organ transplantation

☐ TNF-α antagonist therapy

☐ Viral hepatitis B ever

☐ Viral hepatitis C ever

☐ Other *(specify)* _____

Patient Name _____

23. Inpatient (hospital) during TB workup? ☐ Yes ☐ No

If yes, name of hospital _____

24. Site of disease *(Select all that apply.)*

☐ Pulmonary
☐ Pleural
☐ Lymphatic: cervical
☐ Lymphatic: intrathoracic
☐ Lymphatic: axillary
☐ Lymphatic: other
☐ Lymphatic: unknown
☐ Laryngeal
☐ Bone and/or joint
☐ Genitourinary
☐ Meningeal
☐ Peritoneal
☐ Other _____
☐ Site Not Stated

25. Clinical symptoms *(Select all that apply.)*

☐ Prolonged productive cough
☐ Hemoptysis
☐ Chest pain
☐ Night sweats
☐ Fever
☐ Chills
☐ Weight loss
☐ Other _____
☐ Fatigue
☐ Loss of appetite
☐ None

Date of onset of symptoms *(month, day, year)* _____

26. TB skin test

☐ Positive ☐ Negative ☐ Not done

Date placed *(month, day, year)* _____
Date read *(month, day, year)* _____

Results _____mm

27. Interferon Gamma Release Assay (IGRA) test type

☐ **QuantiFERON (QFT)**
☐ Positive ☐ Negative ☐ Indeterminate ☐ Not done

☐ **T-SPOT**
☐ Positive ☐ Negative ☐ Borderline ☐ Invalid ☐ Not done

Date collected *(month, day, year)* _____

28. Radiology / Other chest imaging study

Initial chest X-ray

☐ Consistent with TB ☐ Not consistent with TB ☐ Not done

If consistent with TB, evidence of cavity? ☐ Yes ☐ No
If consistent with TB, evidence of miliary TB? ☐ Yes ☐ No

Date of chest X-ray *(month, day, year)* _____
Previous chest X-ray Date *(month, day, year)* _____

Initial chest CT scan or other imaging study

☐ Consistent with TB ☐ Not consistent with TB ☐ Not done

If consistent with TB, evidence of cavity? ☐ Yes ☐ No
If consistent with TB, evidence of miliary TB? ☐ Yes ☐ No

Date of CT / other imaging *(month, day, year)* _____
Previous CT / other imaging Date *(month, day, year)* _____

29. Laboratory performing testing

☐ Indiana Department of Health Lab

☐ Other lab *(specify)* _____

30. Sputum smear *(Select one.)*

☐ Positive ☐ Negative ☐ Not done ☐ Pending

Date of collection *(month, day, year)* _____

31. Sputum culture *(Select one.)*

☐ Positive ☐ Negative ☐ Not done ☐ Pending

Date of collection *(month, day, year)* _____

Patient Name _____

32. Nucleic Acid Amplification Test results *(Select one.)*

☐ Positive ☐ Negative ☐ Indeterminate ☐ Not done ☐ Pending

Date of collection *(month, day, year)* _____

Specimen type ☐ Sputum

If not sputum, specify type of specimen _____

33. Smear / Pathology / Cytology of Tissue and other body fluids *(Select one.)*

☐ Positive ☐ Negative ☐ Not done ☐ Pending

Date of collection *(month, day, year)* _____

Type of exam *(Select all that apply.)* ☐ Smear ☐ Pathology/Cytology

Specify type of specimen _____

34. Culture of tissue and other body fluids *(Select one.)*

☐ Positive ☐ Negative ☐ Not done ☐ Pending

Date of collection *(month, day, year)* _____

Specify type of specimen _____

35. Initial drug regimen

☐ Isoniazid Dose _____ Frequency _____

☐ Rifampin Dose _____ Frequency _____

☐ Pyrazinamide Dose _____ Frequency _____

☐ Ethambutol Dose _____ Frequency _____

☐ Vitamin B6 Dose _____ Frequency _____

☐ Other *(specify)* _____

36. Patient's current weight _____ pounds / 2.2 = _____ Kg

37. Date therapy started *(month, day, year)* _____

Notes:

Patient Name _____