REPORT OF TUBERCULOSIS

State Form 14058 (R11 / 5-23)
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 one (1) working day in accordance with 410 IAC 1-2.5.

1. Patient name *(Last, First, Middle Initial)*

____

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 ever 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 ever 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 ever 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 ____________________________________