Patient's Name	asti	(First) (M.I.)			REPORT OF VERIFIED CASI
Street Address		(willy		710	OF TUBERCULOSIS
APER HEAVNIEG PERPAR	REPORT OF V	/ERIFIED CASE OF		U.S. DEPARTM FORM AF PATIENT	CODE)  MENT OF HEALTH AND HUMAN SERVICES PROVED OMB NO. 0920-0026 Exp. Date 05/31/201  TELEPHONE
1. Date Reported		3. Case Numbers			
Month Day  2. Date Submitted  Month Day	Year	State Case Number  City/County Case Number  Linking State Case Number  Linking State Case Number	d (YYY) State	Code Locally Assigned	Reason:
(4 Parantina Addansa 6 a 0	0				
4. Reporting Address for Carlot Within City Limits  County ZIP CODE  5. Count Status (select one)  Countable TB Case  Count as a TB case  Noncountable TB Case: Count another U.S. area (e)  Verified Case: TB truinitiated in another of Specify.  Verified Case: Recuments after complete.	(select one)  (6. Districted by .g., county, state) eatment country  (f)  rrent TB within 12	ate Counted  Month Day  revious Diagnosis of TB Disea  Yes No  YES, enter year of previous TB di		(select one) Yes Country of birth: Specify_  13. Month-Year Arrived in U	
14. Pediatric TB Patients (<1 Country of Birth for Primar Guardian 1 Guardian 2 Patient lived outside U.S. f (select one) If YES, list countries, special 15. Status at TB Diagnosis (s Alive Dead  If DEAD, enter date of deat If DEAD, was TB a cause of	y Guardian(s): Specify  or >2 months? Yes  fy:  elect one)  Month Day	s No Unknown	Pulmoni Pleural Lympha Lympha Lympha	Genitouri tic: Cervical	nary al Iter anatomic code(s)

Public reporting burden of this collection of information is estimated to average 35 minutes per response, 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, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0026). Do not send the completed form to this address.

Information contained on this form which would permit identification of any individual has been collected with a guarantee that it will be held in strict confidence, will be used only for surveillance purposes, and will not be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 U.S.C. 242m).

(Last)	(First)	State Case No (M.I.)	REPORT OF VERIFIED CAS OF TUBERCULOSI
REPORT OF VERIFIED	CASE OF TUBERCULO	SIS	
17. Sputum Smear (select one)	Date Collected:	2-10-1000 A	
Positive Not Done	Month Day	Year	
Negative Unknown			
18. Sputum Culture (select one)	Date Collected:		Date Result Reported:
Positive Not Done	Month Day	Year	Month Day Year
☐ Negative ☐ Unknown			
	Reporting Laboratory Type	(select one): Public	
19. Smear/Pathology/Cytology of T	issue and Other Body Fluids (select	one)	,
Positive Not Done	Date Collected:	TYPE:	Enter anatomic code Type of exam (select all that apply):
☐ Negative ☐ Unknown	Month Day	Year	(See list):
			☐ Smear ☐ Pathology/Cytology
20. Culture of Tissue and Other Boo	ly Fluids (select one)		Enter
Positive Not Done	Date Collected:	Et	anatomic code (see list): Date Result Reported:
☐ Negative ☐ Unknown	Month Day	Year	(see list): Month Day Year
	Reporting Laboratory Type (	select one): Public l Labora	
21. Nucleic Acid Amplification Test I	Result (select one)		
Positive Not Done	Date Collected:		Data Bassiti Dassiti I
☐ Negative ☐ Unknown		'ear	Date Result Reported:  Month Day Year
Indeterminate			
_ modernmate		<del></del>	Reporting Laboratory Type (select one):
	Enter specimen type: Sputum  OR		Cammoroid -
	If not Sputum, enter anatomic code	(see list):	Laboratory Laboratory Other
nitial Chest Radiograph and Other (	Chest Imaging Study DAbnor	mat (NOT cons	pistent with TB)
22A. Initial Chest Radiograph (select one)	Normal Abnormal* (consisten	t with TB)	Oone Unknown
(00/001 0//0)			vidence of a cavity (select one): Yes No Unknown
DATE:		Ev	ridence of miliary TB (select one): Yes No Unknown
22B. Initial Chest CT Scan or Other Chest Imaging	Normal Abnormal* (consisten	t with TB) Not D	
Study (select one)	* For ABNORMAL Init	ial Chest Radiograph: Ev	ridence of a cavity (select one):
DATE	Abnormal * (Not cons	iskntwin TB) <sup>E</sup> \	ridence of miliary TB (select one): Yes No Unknown
23. Tuberculin (Mantoux) Skin Test at Diagnosis (select one)			25. Primary Reason Evaluated for TB Disease (select one)
Positive Not Done	ate Tuberculin Skin Test (TST) Placed		
□ Negative □ Unknown [	Month Day Year	of induration	1 1
- I TOGULTO - OTIVITOWIT			Abnormal Chest Radiograph (consistent with TB)  Contact Investigation
4. Interferon Gamma Release Assay	Date Collected:		Targeted Testing
for Mycobacterium tuberculosis a		Year	Health Care Worker
(select one)			Employment/Administrative Testing
☐ Positive ☐ Not Done	<u> </u>	— I — — — — — — — — — — — — — — — — — —	Immigration Medical Exam
Negative Unknown	Test type:		☐ Incidental Lab Result
☐ Indeterminate	Specify		Unknown

Patient's Ivame	(Last)		irst)	State Ca	se No		<del></del>	REPORT OF VERIFIED CAS	
	(Cast)	(r	1151)	(M.I.)				OF TUBERCULOS	
REPORT OF VERIFIED CASE OF TUBERCULOSIS									
26. HIV Status at Time	of Diagnosis (sele	ct one)	· · · · · · · · · · · · · · · · · · ·					- 1	
Negative	Indeterminate	1	Not Offered		Unknown				
☐ Positive	Refused		est Done, Results	s Unknown					
If POSITIVE, enter:	<del></del>								
State HIV/AIDS Patient Number:					/County HIV/AIDS ent Number:				
27. Homeless Within Past Year (select one)  28. Resident of Correctional Facility at Time of Diagnosis (select one)  No Yes Unknown									
			(select one):	-		_		If YES, under custody of	
□No □Yes	Unknown	LJ Fed	eral Prison	Local Jail		Other C	orrectional Facility	Immigration and Customs Enforcement? (select one)	
			e Prison	Juvenile Corre	ction Facility	Unknow	n	□ No □ Yes	
29. Resident of Long-1 If YES, (select one):	29. Resident of Long-Term Care Facility at Time of Diagnosis (select one) No Yes Unknown								
Nursing Home	Reside	ntial Facility	,	Alcohol or E	Orug Treatment Fa	cility	Unknown		
☐ Hospital-Based F	acility  Mental	Health Res	idential Facility		Term Care Facility		LI OTRIOWN		
30. Primary Occupation						, 			
Health Care Worl	ker 🔲	Migrant/Sea	asonal Worker	Retired	☐ Not Seekir	na Employm	ent (e.a. student hor	nemaker, disabled person)	
Correctional Faci	lity Employee 🔲	Other Occu	pation	Unemployed		.gp	en (eig. stadont, nor	nemaker, disabled person)	
31. Injecting Drug Use Within Past Year 32. Non-Injecting Drug Use Within Past Year 33. Excess Alcohol Use Within Past Year									
□ No	Yes I	Jaknowa	(select one)	□ No □	Yes Unkno	wn	(select one)	Yes Unknown	
34. Additional TB Risk	Factors (select all th	nat apply)		· · · · · · · · · · · · · · · · · · ·				Britinowii	
Contact of MDR-	TB Patient (2 years	or less)	Incomplete	LTBI Therapy	Diabetes Me	ellitus	Other Spe	aciti.	
Contact of Infecti	ous TB Patient (2 ye	ears or less)			☐ End-Stage F				
Missed Contact (		,	Post-organ		Immunosup				
35. Immigration Status		e U.S. (sele		<u> </u>				~	
Not Applicable					☐ Immigrant Vis	sa 🔲	Tourist Visa	Asylee or Parolee	
				Family/Fiancé Visa	Other Immigration Status				
Born in 1 of the U.S. Territories, U.S. Island Areas, or U.S. Outlying Areas     Employment Visa    Refugee    Unknown  Unknown									
Unknown									
36. Date Therapy Starte	ed .	18	7. Initial Drug R	egimen (select o	one option for each	h drua)			
Month Day	Year			No Yes Unk		No Yes U	<del>,</del>	No Yes Unk	
	<i>(b)</i>		Isoniazid		Ethionamide		Moxifloxacin		
			Rifampin		Amikacin		Cycloserine		
			Pyrazinamide		Kanamycin		Para-Amino Salicylic Acid		
			Ethambutol		Capreomycin		Other		
			Streptomycin		Ciprofloxacin		Specify		
			Rifabutin		Levofloxacin		Other		
			Rifapentine		Ofloxacin		Specify		
Comments:	2								
SEPORT SUBMITTED BY: AGENCY - INSTITUTION:									
- PAYERIAN-S OF	RECORD: NAME .				CDRESS:		TELEPHONE		

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