

Patient's Name: \_\_\_\_\_  
(Last) (First) (M.I.)

**REPORT OF VERIFIED CASE  
 OF TUBERCULOSIS**

Street Address: \_\_\_\_\_  
(Number, Street, City, State) Zip Code



**REPORT OF VERIFIED CASE OF TUBERCULOSIS**

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
 PUBLIC HEALTH SERVICE  
 CENTERS FOR DISEASE CONTROL  
 AND PREVENTION (CDC)  
 ATLANTA, GEORGIA 30333

FORM APPROVED OMB NO. 0920-0026 Exp. Date 11/95

**Initial Drug Susceptibility Report**

**(Follow Up Report - 1)**

**SOUNDEX**

<b>State Reporting:</b> Specify: _____ Alpha State Code <input type="text"/> <input type="text"/>	<b>Year Counted:</b> <input type="text"/> <input type="text"/>	<b>State Case Number:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
		<b>City/County Case Number:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

**Submit this report for all culture-positive cases.**

**33. Initial Drug Susceptibility Results:**

Was Drug Susceptibility Testing Done: 0  No 1  Yes 9  Unknown  
*If answer is No or Unknown, do not complete rest of report.*

If Yes,  
 Enter Date First Isolate Collected  
 for Which Drug Susceptibility Was Done?   Mo.   Day   Yr.

**34. Susceptibility Results:**

	<u>Resistant</u>	<u>Susceptible</u>	<u>Not Done</u>	<u>Unknown</u>
Isoniazid	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Rifampin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Pyrazinamide	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Ethambutol	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Streptomycin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Ethionamide	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Kanamycin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Cycloserine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Capreomycin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Para-Amino Salicylic Acid	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Amikacin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Rifabutine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Ciprofloxacin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Ofloxacin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Other	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>

**Comments:**

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 .....  
 .....

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).