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

Street Address: _____ (Number, Street, City, State) _____ Zip Code)

REPORT OF VERIFIED CASE OF TUBERCULOSIS

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

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

Case Completion Report

(Follow Up Report – 2)

SOUNDEX ☐☐☐☐

State Reporting:
Specify: _____
Alpha State Code ☐☐

Year Counted: ☐☐

State Case Number: ☐☐☐☐☐☐☐☐☐☐

City/County Case Number: ☐☐☐☐☐☐☐☐☐☐

35. Sputum Culture Conversion Documented:
0 ☐ No 1 ☐ Yes 9 ☐ Unknown

If Yes, Date Specimen Collected on Initial Positive Sputum Culture: Mo. ☐☐ Day ☐☐ Yr. ☐☐

If Yes, Date Specimen Collected on First Consistently Negative Culture: Mo. ☐☐ Day ☐☐ Yr. ☐☐

36. Date Therapy Stopped: Mo. ☐☐ Day ☐☐ Yr. ☐☐

37. Reason Therapy Stopped:
1 ☐ Completed Therapy
2 ☐ Moved
3 ☐ Lost
4 ☐ Uncooperative or Refused
5 ☐ Not TB
6 ☐ Died
7 ☐ Other
9 ☐ Unknown

38. Type of Health Care Provider:
1 ☐ Health Department
2 ☐ Private/Other
3 ☐ Both Health Department and Private/Other

39. Directly Observed Therapy:
0 ☐ No, Totally Self-Administered
1 ☐ Yes, Totally Directly Observed
2 ☐ Yes, Both Directly Observed and Self-Administered
9 ☐ Unknown

If Yes, Give Site(s) of Directly Observed Therapy:
1 ☐ In Clinic or Other Facility
2 ☐ In the Field
3 ☐ Both in Facility and in the Field
9 ☐ Unknown

Number of Weeks of Directly Observed Therapy: Weeks ☐☐☐

40. Final Drug Susceptibility Results:
Was Follow-up Drug Susceptibility Testing Done? 0 ☐ No 1 ☐ Yes 9 ☐ Unk.

If answer is No or Unknown, do not complete rest of report.

If Yes, Enter Date Final Isolate Collected for Which Drug Susceptibility Was Done: Mo. ☐☐ Day ☐☐ Yr. ☐☐

41. Final Susceptibility Results:

	Resistant	Susceptible	Not Done	Unknown
Isoniazid	1 ☐	2 ☐	3 ☐	9 ☐
Rifampin	1 ☐	2 ☐	3 ☐	9 ☐
Pyrazinamide	1 ☐	2 ☐	3 ☐	9 ☐
Ethambutol	1 ☐	2 ☐	3 ☐	9 ☐
Streptomycin	1 ☐	2 ☐	3 ☐	9 ☐
Ethionamide	1 ☐	2 ☐	3 ☐	9 ☐
Kanamycin	1 ☐	2 ☐	3 ☐	9 ☐
Cycloserine	1 ☐	2 ☐	3 ☐	9 ☐

	Resistant	Susceptible	Not Done	Unknown
Capreomycin	1 ☐	2 ☐	3 ☐	9 ☐
Para-Amino Salicylic Acid	1 ☐	2 ☐	3 ☐	9 ☐
Amikacin	1 ☐	2 ☐	3 ☐	9 ☐
Rifabutine	1 ☐	2 ☐	3 ☐	9 ☐
Ciprofloxacin	1 ☐	2 ☐	3 ☐	9 ☐
Ofloxacin	1 ☐	2 ☐	3 ☐	9 ☐
Other	1 ☐	2 ☐	3 ☐	9 ☐

Comments:

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).