CONFIDENTIAL REPORT OF VERIFIED CASE OF TUBERCULOSIS (2020 RVCT)
RHODE ISLAND DEPARTMENT OF HEALTH
CENTER FOR HIV, VIRAL HEPATITIS, STD, AND TB EPIDEMIOLOGY
3 Capitol Hill, Room 106, Providence, RI 02908
PHONE: (401) 222-2577 | FAX: (401) 222-2488
Mail or fax case report form within 4 days of diagnosis.

Clear Form

I. PATIENT INFORMATION:

Last Name	**First (full) Name**	**MI**	**Date of Birth** _____ /_____ / _____	**Age**

Street/Apt	**Sex at Birth** ☐ Male ☐ Female ☐ Unknown	**Gender Identity** ☐ Male ☐ Female ☐ Unknown ☐ Trans Male ☐ Trans Female ☐ Other

City	**State**	**Zip**	**Phone Number**:

9. Ethnic Origin:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown/Not Provided

10. Race (check all that apply):
☐ American Indian or Alaskan Native
☐ Asian: *specify:* _____
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Other: *specify:* _____
☐ Unknown/Not Provided

11A. Country of Birth:
☐ United States
☐ Not U.S., *specify:*

_____

If not born in the U.S., date of U.S. arrival:

____ /_____ / _____

11B. Eligible for U.S. Citizenship/ Nationality at Birth?
☐ Yes
☐ No
☐ Unknown

11C. Countries of Birth for Primary Guardian(s) [PEDIATRIC CASES <15 ONLY]
☐ Guardian 1: _____
☐ Guardian 2: _____

12A. Country of Usual Residence:

_____

12B. If NOT U.S. Reporting Area, Has Patient Been in United States for ≥90 days (inclusive of Report Date)
☐ Yes
☐ No
☐ Unknown

13. Status at TB Diagnosis: ☐ Alive ☐ Deceased

II. DISEASE & RISK INFORMATION:

14. Initial Reason Evaluated for TB:
☐ TB Symptoms
☐ Screening
☐ Contact Investigation
☐ Other
☐ Unknown

15A. Has patient ever worked as one of the following?
☐ Healthcare Worker
☐ Correctional Facility Employee
☐ Migrant/Seasonal Worker
☐ None of the Above
☐ Unknown

15B. Patient Current Occupation and Industry:

_____

16. Other Risk Factors
☐ Diabetic
☐ Homeless in the past 12 months
☐ Homeless ever
☐ Resident of correctional facility ever
☐ Resident of long-term care facility
☐ Injecting drug use in past 12 months
☐ Non-injecting drug use in past 12 months
☐ Heavy alcohol use in past 12 months
☐ TNF-α antagonist therapy
☐ Post-organ transplantation
☐ End-stage renal disease
☐ Viral hepatitis B or C
☐ Other immunocompromise (not HIV/AIDS)
☐ Other: *specify:* _____
☐ None

17. If resident of correctional facility at diagnostic evaluation, type of facility? ☐ N/A
☐ Federal Prison ☐ Juvenile Facility
☐ State Prison ☐ Other
☐ Local Jail ☐ Unknown

18. If resident of long-term care facility at diagnostic evaluation, type of facility? ☐ N/A
☐ Nursing Home ☐ Mental health residential
☐ Hospital-based ☐ Drug or alcohol treatment
☐ Residential ☐ Other: _____

19. Current Smoking Status:
☐ Current, every day ☐ Former smoker
☐ Current, some days ☐ Never smoker
☐ Current, status unknown ☐ Unknown if ever smoked

20. Lived Outside the United States for >2 months (uninterrupted)?
☐ Yes ☐ No ☐ Unknown

III. DIAGNOSTIC & TESTING INFORMATION:

21. Tuberculin Skin Test (TST): ☐ Not Done
☐ Negative
☐ Previous (+)
☐ Positive // Induration: _____mm

Date Collected: _____ /_____ / _____

Date Read: _____ /_____ / _____

Interferon Gamma Release Assay (IGRA):

Test Type:
☐ QuantiFERON (QFT)
☐ T-Spot
☐ Unknown
☐ Not Done

Result:
☐ Positive
☐ Negative
☐ Indeterminate

Date Collected: _____ /_____ / _____

HIV Status: ☐ Positive ☐ Negative ☐ Unknown

Date: _____ /_____ / _____ If (+), CD4 count: _____

Hemoglobin A1c: _____
Fasting Blood Glucose: _____
Other: _____

Smear: ☐ Positive // AFB (check one): ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+
☐ Negative
☐ Pending
☐ Not Done

Specimen is Sputum: ☐ Yes
☐ No, anatomic site:

Collection Date: _____ /_____ / _____

Culture: ☐ Positive
☐ Negative
☐ Pending
☐ Not Done

Specimen is Sputum: ☐ Yes
☐ No, anatomic site: _____

Collection Date: _____ /_____ / _____

22. Chest Radiography
☐ X-ray
☐ CT Scan
☐ MRI
☐ PET
☐ Other: _____
☐ Not Done
☐ Unknown

Result:
☐ Consistent with TB
☐ Not consistent with TB
☐ Unknown

If consistent with TB:
☐ Cavitary
☐ Miliary
☐ Unknown
☐ Non-cavitary, non-miliary

23. Previous diagnosis of TB disease or LTBI?
☐ TB Disease ☐ LTBI ☐ No history ☐ Unknown

If yes, previously diagnosed:
☐ Year of Diagnosis: _____
☐ State of Diagnosis: _____

Completed Treatment?
☐ Yes
☐ No
☐ Unknown

24. Date of Illness Onset / Symptom Start Date: _____ /_____ / _____

25. Site of Disease (check all that apply):
☐ Pulmonary
☐ Pleural
☐ Lymphatic cervical
☐ Lymphatic intrathoracic
☐ Lymphatic axillary
☐ Lymphatic other
☐ Lymphatic unknown
☐ Laryngeal
☐ Bone and/or joint
☐ Genitourinary
☐ Meningeal
☐ Peritoneal
☐ Other: *specify:* _____
☐ Unknown

26. Case meets binational reporting criteria?
☐ Yes
☐ No
☐ Unknown

27. Case identified during contact investigation for another case?
☐ Yes
☐ No
☐ Unknown

If yes, was patient evaluated for TB during that contact investigation?
☐ Yes
☐ No
☐ Unknown

28. Is a contact investigation being conducted for this case?
☐ Yes
☐ No
☐ Unknown

If yes: ☐ Household ☐ Institutional: _____
☐ Other ☐ Unknown

29. Contact Name	**Contact DOB**	**Relationship**	**Epidemiologic Link**
_____	____/_____/_____	_____	☐ Definite ☐ Probable
_____	____/_____/_____	_____	☐ Definite ☐ Probable
_____	____/_____/_____	_____	☐ Definite ☐ Probable
_____	____/_____/_____	_____	☐ Definite ☐ Probable

IV. TREATMENT & DRUG RESISTANCE INFORMATION:

30. Date Therapy Started: _____ /_____ / _____

31. Initial Drug Regimen (check all that apply):

- ☐ Isoniazid
- ☐ Rifampin
- ☐ Pyrazinamide
- ☐ Ethambutol
- ☐ Streptomycin
- ☐ Rifabutin
- ☐ Lymphatic unknown
- ☐ Rifapentine
- ☐ Ethionamide
- ☐ Amikacin
- ☐ Kanamycin
- ☐ Capreomycin
- ☐ Levofloxacin
- ☐ Ofloxacin
- ☐ Moxifloxacin
- ☐ Cycloserine
- ☐ Para-Amino Salicylic Acid
- ☐ Linezolid
- ☐ Bedaquiline
- ☐ Delaminid
- ☐ Clofazimine
- ☐ Pretomanid
- ☐ Other: _____

32. If initial drug regimen is not RIPE / HRZE, why not?

- ☐ Drug contraindication/interaction
- ☐ Drug susceptibility testing results already known
- ☐ Suspected drug resistance
- ☐ Drug shortage
- ☐ Other: _____
- ☐ Unknown

33. Isolate submitted for genotyping?

- ☐ Yes
- ☐ No
- ☐ Unknown

Accession Number: _____

34. Was phenotypic/growth-based drug susceptibility testing done? ☐ Yes ☐ No ☐ Unknown ☐ Not Done

If yes:

☐ Resistant: _____ ☐ Susceptible ☐ Unknown

Specimen source: _____ Date collected: _____ /_____ / _____ Date Reported: _____ /_____ / _____

35. Was genotypic/molecular drug susceptibility testing done? ☐ Yes ☐ No ☐ Unknown ☐ Not Done

- ☐ Mutation Detected
- ☐ Mutation Not Detected
- ☐ Unknown

- ☐ Nucleic Acid Change
- ☐ Amino Acid Change

- ☐ Insertion
- ☐ Deletion
- ☐ Indel
- ☐ Unknown

- ☐ Non-sequencing
- ☐ Sequencing
- ☐ Unknown

Specimen source: _____ Date Collected: _____ /_____ / _____ Date Reported: _____ /_____ / _____

36. Was the patient treated as an MDR TB Case (regardless of DST results)? ☐ Yes ☐ No ☐ Unknown

37. Sputum culture conversion documented? ☐ Yes ☐ No ☐ Unknown

If yes, date collected for first consistently negative culture: _____ /_____ / _____

If no, reason why not:

- ☐ No follow-up sputum despite induction
- ☐ No follow-up sputum and no induction
- ☐ Patient Refused
- ☐ Patient Died
- ☐ Patient Lost to Follow Up
- ☐ Other: _____
- ☐ Unknown

38. Did patient move during therapy? ☐ Yes ☐ No ☐ Unknown

If yes: ☐ Out of State ☐ Out of the U.S.

Specify State or Country: _____

If moved outside the U.S., was a transnational referral made with CureTB or TBNet (circle one)? ☐ Yes ☐ No ☐ Unknown

39. Date Therapy Stopped: _____ /_____ / _____

40. Reason Therapy Stopped or Never Started:

- ☐ Completed therapy
- ☐ Lost to follow up
- ☐ Patient choice
- ☐ Adverse treatment event
- ☐ Not TB
- ☐ Patient Died
- ☐ Patient Dying
- ☐ Other: _____
- ☐ Unknown

41. Reason Therapy Extended >12 Months, if applicable:

- ☐ Inability to use rifampin (resistance, intolerance, etc.)
- ☐ Adverse drug reaction
- ☐ Non-adherence
- ☐ Failure
- ☐ Clinically indicated – other reasons
- ☐ Other: _____
- ☐ Unknown

42. Treatment Administration: ☐ DOT ☐ EDOT ☐ Self-Administered

43. Did patient die (either before diagnosis or at any time during treatment)? ☐ Yes ☐ No ☐ Unknown

If yes, date of death: _____ /_____ / _____ Did TB disease or therapy contribute? ☐ Yes ☐ No ☐ Unknown

V. FOR MDR CASES ONLY:

1. History of treatment before current episode: ☐ Yes ☐ No ☐ Unknown

2. Date MDR TB Therapy started for current episode: _____ /_____ / _____

3. Drugs Ever Used for MDR Treatment:

Drug Name: _____ Length of Time Administered: _____
Drug Name: _____ Length of Time Administered: _____
Drug Name: _____ Length of Time Administered: _____

4. Date Injectable Medication Stopped (leave blank if none used): _____ /_____ / _____

5. Was surgery performed to treat MDR TB? ☐ Yes ☐ No ☐ Unknown

6. Side effects: _____ Experienced: ☐ During Rx ☐ After Rx ☐ Both

VI. FOR LATENT TB INFECTION (LTBI) ONLY:

1. Date Therapy Started: _____ /_____ / _____

2. Regimen: ☐ RIF ☐ INH ☐ 3HP ☐ Other:

3. Expected End of Therapy Date: _____ /_____ / _____

4. Completed Treatment? ☐ Yes ☐ No ☐ Unknown

5. Treatment Administration ☐ DOT ☐ EDOT ☐ Self

6. Reason Therapy Stopped: ☐ Completed therapy ☐ Lost to follow up ☐ Patient choice ☐ Adverse event ☐ Not LTBI ☐ Patient Died ☐ Other: _____ ☐ Unknown

VII. REPORTING FACILITY INFORMATION

Person Completing Form: _____

Date of Report: _____/ _____/ _____

Facility Name: _____

Facility Telephone Number: _____

Physician Caring for Patient: _____

Physician Contact Number: _____

For additional guidance on completing this case report form, please see CDC's 2020 Report of Verified Case of Tuberculosis (RVCT) Reference Manual.