

The EDN Tuberculosis Follow-Up Worksheet for Newly-Arrived Persons with Overseas Tuberculosis Classifications

Alien # _____

U.S. Review of Pre-Immigration Treatment

C9a. Completed treatment pre-immigration? Yes No
 Unknown

If YES, C9b. Treated for TB disease Treated for LTBI
 Treated, but unknown if TB disease or LTBI

If Treated for TB disease,

Treatment completed prior to panel physician examination
 Treatment completed after panel physician diagnosis (DS 3030)
 At designated DOT site
 At non-designated DOT site
 Other, specify: _____

C9c. Treatment start date: ___/___/___ Start date unknown

C9d. Treatment end date: ___/___/___ End date unknown

C9e. Report of treatment administered prior to panel physician examination:

Treatment documented on overseas medical history form (DS 3026)
 Documented on DS forms & patient reported at panel physician examination
 After U.S. arrival only, patient verbally reported treatment completion
 Unknown

C9f. Standard TB treatment regimen was administered?

Yes No Unable to verify

C10a. Arrived to the U.S. on treatment?

Yes No
 Unknown

If YES, C10b. Treated for TB disease Treated for LTBI

C10c. Start date: ___/___/___ Start date unknown

C11a: Pre-Immigration treatment concerns?

Yes No

If YES, C11b. Select all that apply:

Treatment duration too short
 Incorrect treatment regimen
 Inadequate information provided
 Lack of adequate diagnostics
 Unknown DOT/adherence status
 Other, please specify: _____

C12. U.S. Microscopy/Bacteriology* Sputa collected in U.S.? Yes No *Covers all results regardless of sputa collection method.

#	Date Collected	AFB Smear		Sputum Culture		Drug Susceptibility Testing	
1	___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> NTM	<input type="checkbox"/> MTB Complex	<input type="checkbox"/> MDR-TB	<input type="checkbox"/> Mono-RIF
		<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown	<input type="checkbox"/> Contaminated	<input type="checkbox"/> Negative	<input type="checkbox"/> Mono-INH	<input type="checkbox"/> Other DR
				<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown	<input type="checkbox"/> No DR	<input type="checkbox"/> Not Done
2	___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> NTM	<input type="checkbox"/> MTB Complex	<input type="checkbox"/> MDR-TB	<input type="checkbox"/> Mono-RIF
		<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown	<input type="checkbox"/> Contaminated	<input type="checkbox"/> Negative	<input type="checkbox"/> Mono-INH	<input type="checkbox"/> Other DR
				<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown	<input type="checkbox"/> No DR	<input type="checkbox"/> Not Done
3	___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> NTM	<input type="checkbox"/> MTB Complex	<input type="checkbox"/> MDR-TB	<input type="checkbox"/> Mono-RIF
		<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown	<input type="checkbox"/> Contaminated	<input type="checkbox"/> Negative	<input type="checkbox"/> Mono-INH	<input type="checkbox"/> Other DR
				<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown	<input type="checkbox"/> No DR	<input type="checkbox"/> Not Done

D. Evaluation Disposition in U.S.

D1a. Evaluation disposition date in U.S.: ___/___/___

D1b. State/jurisdiction of evaluation disposition in U.S.: _____

D2a. Evaluation disposition in U.S.:

Completed evaluation Initiated Evaluation / Not completed Did not initiate evaluation

D2b. If evaluation was completed, was treatment recommended?

Yes No
 LTBI
 Active TB

D2c. If evaluation was NOT completed, why not? Select all that apply.

Not Located Moved within U.S., transferred to: _____ State/jurisdiction
 Lost to Follow-Up Moved outside U.S.
 Refused Evaluation Died
 Unknown Other, specify: _____

D3. Diagnosis

Class 0 - No TB exposure, not infected or Class 1 - TB exposure, no evidence of infection
 Class 2 - TB infection, no disease Class 3 - TB, TB disease
 Class 4 - TB, inactive disease Pulmonary Extra-pulmonary Both sites

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D4. If diagnosed with TB disease:

State Case Number: _____
 Year State RVCT # / TBLISS #

RVCT # unknown* RVCT Reported*

TBLISS # unknown* TBLISS Reported*

City/County Case Number: _____
 Year State RVCT # / TBLISS #

*Note: Either the RVCT or TBLISS number may be reported.

E. U.S. Treatment for TB Disease or TB Infection

E1a. U.S. treatment initiated: Yes No Unknown

E1b. If NO, specify the reason. Select all that apply:

- Patient declined against medical advice
- Lost to follow-up
- Moved within U.S., transferred to: _____
State/jurisdiction
- Died
- Moved outside the U.S.
- Prior treatment completed (year: _____)
- Currently on treatment
- Treatment not offered based on local clinic guidelines
- Unknown
- Contraindication for treatment
- Other, specify: _____

E1c. If YES: Treated for TB disease Treated for LTBI

E2. Treatment start date: ___/___/___ E3. State/jurisdiction of treatment in U.S.: _____

E4. Specify initial LTBI regimen:

- Isoniazid (9 months; 9H)
- Isoniazid (6 months; 6H)
- Isoniazid/Rifapentine (3 months; 3HP)
- Isoniazid/Rifampin (INH+RIF; 4 months)
- Rifampin (4 months; 4R)
- Isoniazid/Rifampin/Ethambutol/Pyrazinamide (RIPE; 2 months; suspected TB disease)
- Unknown
- Other, specify: _____

E5a. U.S. treatment completed: Yes No Unknown

If NO, E5b. Specify the reason. Select all that apply:

- Patient declined against medical advice
- Lost to follow-up
- Moved within U.S., transferred to: _____
State/jurisdiction
- Died
- Moved outside the U.S.
- Unknown
- Dying (treatment stopped because of imminent death, regardless of cause of death)
- Adverse effect
- Other, specify: _____
- Provider decision
- Not TB disease
- Developed TB [For patient diagnosed with LTBI]
- Pregnancy [For patient diagnosed with LTBI]

E6. Date therapy stopped: ___/___/___

Specify reason therapy stopped: _____

F. Evaluation Site Information

Provider's Name:
 Clinic Name:
 Telephone Number:

G. Treatment Site Information

Provider's Name:
 Clinic Name:
 Telephone Number:
 Same as evaluation site information

H. Comments
