



TEXAS HANSEN'S DISEASE PROGRAM C-12 SURVEILLANCE FORM AND TEXAS CASE REPORT

1. Reporting State: 2. Date of Report: 3. Last 4 digits of Social Security Number (optional):

4. Patient Name: (Last) (First) (Middle)

5. Home/Present Address: Street City County State Zip Email Address: Phone #

6. Place of Birth: City State Country 7. Date of Birth: Mo. Day Yr.

8. Ethnicity: Race: 9. Primary Language:

10. Date entered U.S.: 11. Date of onset of symptoms: 12. Date HD first diagnosed: 13. Gender at Birth: 14. Gender Identity: 15. Is patient receiving assistance through local, state, or federal programs for disability?

16. List all places the PATIENT has ever lived (Including Military Service) BEFORE leprosy was diagnosed:

Table with columns: TOWN, COUNTY, STATE, COUNTRY, INCLUSIVE DATES (From: Mo./Yr., To: Mo./Yr.)

17. Type of Leprosy: (ICD-10-CM Code) Tuberculoid A30.1 (TT) Borderline Tuberculoid A30.2 (BT) Indeterminate A30.0 (IN) Borderline A30.3 (BB) Borderline Lepromatous A30.4 (BL) Lepromatous Leprosy A30.5 (LL) Other Specified Leprosy A30.8 Leprosy Unspecified A30.9

18. Diagnosis of Disease: Was initial diagnosis done: Immunological reaction at diagnosis? Was biopsy performed? PCR: Positive Negative

19. Treatment: Start Date: Treatment end date: 20. Current antibiotics for Leprosy: (check all that apply) Rifampin Moxifloxacin Minocycline Dapsone Clofazimine Others:

21. Name of person filling out the form: Phone Number: Fax Number: Email address: Treating Physician/Provider:

Name (Last, First):

DOB:

22. Aliases:		23. Phone Number(s):				
24. Entered Texas: Date: From Where:		25. Citizen of:		26. Education Level:	27. Employment:	
28. Health Insurance: Medicare Medicaid BC/BS Private Insurance None						
29. Armadillo Contact? Yes No Unknown Describe:						
30. Date of Onset of Symptoms: / / Give Brief Description & History Prior to Diagnosis:						
31. Diagnosing Physician Information (indicate Yes or No if this is also the treating physician): Yes No Name: Address: City: Phone:						
32. Known Contact with Hansen's Disease Case? Yes No Unknown						
(If answered Yes to #32) Name of Suspected Source		DOB	Sex	Relationship	Household Contact	Inclusive Dates of Contact

Name (Last, First):

DOB:

33. Contact Surveillance: If not listed on page 2 #32, or when more details are needed for the Follow-up. *A contact is any individual who has shared the same enclosed air space in a household or other enclosed environment for a prolonged period with a person who has an untreated case of HD.*

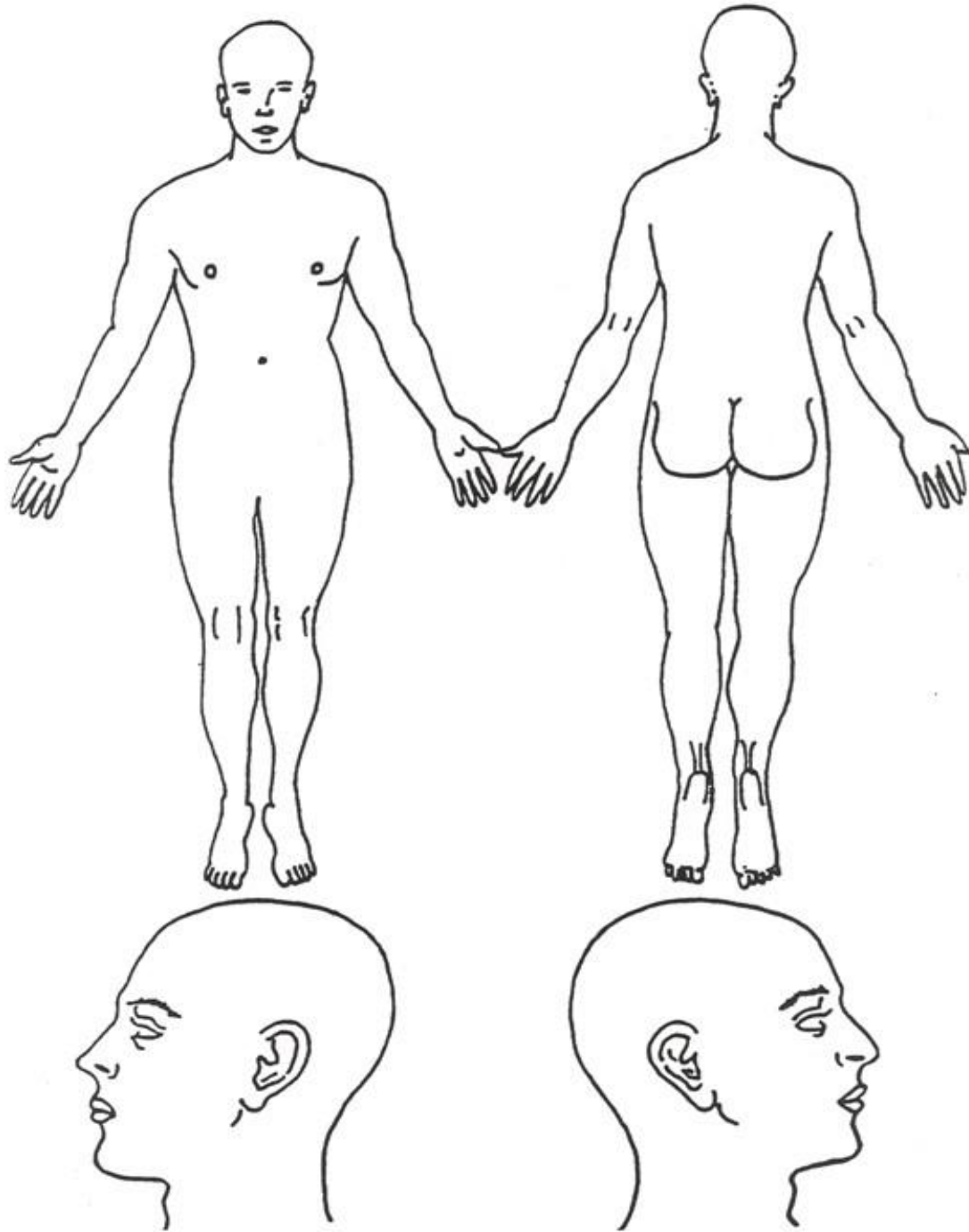
Name	DOB	Inclusive Contact Dates		Address	Follow-up: Date and Status, if contact was assessed in clinic C = Case N = Negative, no signs/symptoms S = Suspicious Lesions
Relation to Index		From MM/YY	To MM/YY		

Name (Last, First):

DOB:

34. Date of Examination: / /

(Mark on the below pictures any physical findings suggestive of Hansen's Disease)



Instructions for Completing the Hansen's Disease (Leprosy) C-12 Surveillance Form

Fill out all surveillance data and patient information, and send to the Texas Department of State Health Services (DSHS) within 3 days. Page 1 is the National Hansen's Disease (NHDP) Surveillance Form, pages 2-4 are required for Texas reporting, pages 5-6 are instructions. Contact DSHS at 737-255-4300 for questions regarding reporting HD in Texas.

ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL

1. **Reporting State:** Use the abbreviation of the state from which the report is being sent. This is usually the state of the clinician's office and not necessarily the patient's resident state.
2. **Date of Report:** This is date of the initial LSF completion. If patient was previously reported and has relapsed, write the word "RELAPSE" next to the date.
3. **Social Security Number (last 4):** Optional; self-explanatory.
4. **Patient Name:** Self-explanatory.
5. **Home/Present Address:** Please include the county and zip code which are used to geographically cluster patients.
6. **Place of Birth:** Include state and city, if born in the U.S., or the country, if foreign born.
7. **Date of Birth:** Self-explanatory.
8. **Race/Ethnicity:** This information should be voluntarily provided by the patient. If the patient refuses or indicates a race/ethnicity category not listed, check the "Not Specified" box.
9. **Primary Language:** Patient's primary language preference.
10. **Date Entered the U.S.:** For patients who have immigrated to the U.S., provide the month and year of entry.
11. **Date of Onset of Symptoms:** This information is usually the patient's recollection of when classic leprosy symptoms (*rash, nodule formation, paresthesia, decreased peripheral sensation, etc.*) were first noticed.
12. **Date Leprosy First Diagnosed:** Provide the month and year a diagnosis was made. This usually coincides with a biopsy date if one was performed.
13. **Gender at Birth:** Gender assigned at birth: M = Male, F = Female, or X = non-binary, indeterminate, intersex, or unspecified.
14. **Gender Identity:** What gender does the patient identify as: M = Male, F = Female, or X = non-binary, indeterminate, intersex, or unspecified.
15. **Disability Assistance:** Is patient receiving any government assistance through local, state or federal programs for disability?
16. **Residence (Pre-diagnosis):** List all cities, counties, and states in the U.S. and all foreign countries a patient resided in BEFORE leprosy was diagnosed. This information is used to map all places where U.S. leprosy cases have resided.
17. **Type of Leprosy:** Classify the diagnosis based on one of the ICD-10-CM diagnosis codes. (NHDP Clinic physicians: Please circle specific classification, if possible). RJ = Ridley-Jopling
 - a. **A30.1 Tuberculoid Leprosy (macular, maculoanesthetic, major, minor, neuritic – includes RJ Tuberculoid [TT] and A30.2 Borderline tuberculoid [BT]):** A form marked by usually one lesion with well-defined margins with scaly surface and local tender cutaneous or peripheral nerves.
 - b. **A30.0 Indeterminate (uncharacteristic, macular, neuritic):** A form marked by one or more macular lesions, which may have slight erythema.
 - c. **A30.3 Borderline (dimorphous, infiltrated, neuritic – includes RJ Borderline [BB] or true mid disease only):** A form marked by early nerve involvement and lesions of varying stages.
 - d. **A30.5 Lepromatous Leprosy (macular, diffuse, infiltrated, nodular, neuritic – includes RJ Lepromatous [C] and A30.4 Borderline lepromatous [BL]):** A form marked by erythematous macules, generalized papular and nodular lesions, and variously by upper respiratory infiltration, nodules on conjunctiva or sclera, and motor loss.
 - e. **A30.8 Other Specified Leprosy:** Use this code when the diagnosis is specified as "leprosy" but is not listed above (*A30.0-A30.3*), including 'pure neural' disease.
 - f. **A30.9 Leprosy, Unspecified:** Use this code when the diagnosis is identified as "leprosy" but inactive.
18. **Diagnosis of the Disease:** Self-explanatory. Was the patient in immunological reaction at diagnosis? Biopsy and PCR done?
19. **Treatment:** Start date and end date (if completed treatment).
20. **Current Treatment for Leprosy:** Date that treatment started and indicate all drugs used for initial treatment.

Instructions (Continued)

21. - 31. **Self-explanatory.**

32. **Known Contact with Hansen's Disease Case:** Indicate if patient is a contact to someone with diagnosed Hansen's Disease. If yes, include suspected source information.

33. **Contact Surveillance:** For contacts not listed on page 1, or when more information is known regarding the status of the contact, list all requested fields.

34. **Date of Examination:** Date of physical exam by physician or HD clinic. Mark/draw on the body part to indicate where signs or symptoms of leprosy occur (rash, nodule formation, paresthesia, decreased peripheral sensation, etc.).