TEXAS Health and Human Services | Texas Department of State Health Services

Tuberculosis (TB) Incident Report

To be submitted for the following events: media sensitive exposures, exposures with ≥ 50 contacts in a single site, K-12 school exposures with ≥ 25 contacts, or exposures deemed concerning by the program. Please submit form via the PHIN (preferred) or fax to 512-533-3167 within 48 hours of incident. Fields may be left blank if information is pending.

Incident Report Information	
Submission Date:	**City of Incident:**
County:	**Region:**
Reporter Information	
Local Contact Person:	**Phone Number:**
Title:	**E-mail:**

Case/Suspect Information

Patient Name: _____

Gender: ☐ Male ☐ Female ☐ Other: _____

DOB: _____

Foreign Born? ☐ Yes ☐ No ☐Unknown

Country of Birth: _____

Arrival Date: _____

Symptom
Onset Date: _____ **End Date**: _____

☐ Cough ☐ Chills ☐ Hemoptysis ☐ Fever ☐ Fatigue
☐ Loss of appetite ☐Night Sweats ☐ Weight loss
☐Other, please specify: _____

Additional comments on symptoms:

Hospitalized? ☐ Yes ☐ No
Name of Hospital: _____
Hospital Dates: _____ to _____
Infectious? ☐ Yes ☐ No
If yes, isolated? ☐ Yes ☐ No
Infectious period: _____ to _____

Started on treatment? ☐ Yes ☐ No ☐ Unknown
Drug start date: _____ Drug end date: _____
Type of Drugs: ☐ INH ☐ RIF ☐ PZA ☐ EMB
☐Other (specify):_____

Case Died? ☐ Yes ☐ No ☐ Unknown
Date of Death: _____
Was TB diagnosis at death? ☐ Yes ☐ No ☐ Unknown
Was TB cause of death? ☐ Yes ☐No ☐ Unknown

TST performed? ☐ Yes ☐ No ☐ Unknown
TST Test Date: _____ TST Read Date: _____
Results (mm): _____ ☐ Positive ☐ Negative

IGRA results: ☐ Positive ☐ Negative ☐ Indeterminate
☐ Unknown ☐ Pending ☐ Not Performed
IGRA Test Date:_____ ☐ T-Spot ☐ QFT

NAAT results: ☐ Positive ☐ Negative ☐ Unknown
☐Pending ☐Not Performed
NAAT Date: _____

AFB Specimen:_____ **Collection Date**: _____
Were specimens sent to DSHS? ☐ Yes ☐ No
AFB Smear results: ☐ Positive ☐ Negative ☐ Unknown
☐Pending ☐Not Performed
ATS Class: ☐ <1 ☐1+ ☐ 2+ ☐ 3+ ☐ 4+
CAP Class: ☐ 1-2/smear ☐<1/field ☐ 1-10/field ☐ >10/field

AFB culture result: ☐ AFB found: *M. tuberculosis* complex
☐ AFB found: Non-*M. tuberculosis complex*
☐ No AFB found ☐ Pending ☐ Not Performed

Additional laboratory comments **(e.g. DSTs, other specimens):**

Chest X-ray performed? ☐ Yes ☐ No ☐ Unknown
Date of CXR: _____ Results: ☐ Abnormal ☐ Normal
Chest X-ray indicates Cavitation? ☐ Yes ☐ No
Chest CT performed? ☐ Yes ☐ No ☐ Unknown
Date of CT: _____ Results: ☐ Abnormal ☐ Normal
Chest CT indicates Cavitation? ☐ Yes ☐ No

Incident Location Information

Facility Types: Daycare, School, College, Workplace, Nursing Home, Hospital, Correctional Facility, Other (specify)

Facility Type	Name and Address	Exposure Dates (mm/dd/yy to mm/dd/yy)

Please describe environment(s) (i.e. large vs. small room, ventilation details):

Estimated Contacts (refer to TB Work plan for prioritization)

Facility	# High Priority Contacts	# Medium Priority Contacts	# Low Priority Contacts	Total # of Contacts

Investigation Activities

Provide a timeline for all screening activities (complete and anticipated). Include specific dates where possible:

Media Involvement

Has the media become involved with this incident? ☐ Yes ☐ No ☐ Possible

If yes, provide name of media source and media contact person (if available) of all media involved below:

For Internal Use Only

Date Report Received:

Report Received by: