EDN TB Follow-Up Worksheet

A. Demographic

Last reviewed: 6/21/2013

A1. Name (Last, First, Middle): ,

A2. Alien #:

A3. Visa type:

A4. Initial U.S. entry date:

A5. Age:

A6. Gender:

A7. DOB: ___/___/______

A8. TB Class:

A9.Country of examination:

A10.Country of birth:

A11a. Address:

A11b. Phone:

A11c. Other:

A12. a. Sponsor agency name:

b. Phone(s):

c. Address:

B. Jurisdictional Information

B1. Arrival jurisdiction:

B2. Current jurisdiction:

C. U.S. Evaluation

C1. Date of Initial U.S. medical evaluation: ___/___/______

Mantoux Tuberculin Skin Test (TST)

C2a. Was a TST administered? ☐ Yes ☐ No ☐ Unknown

If YES, C2b. TST placement date: ___/___/______

☐ Placement date unknown

C2c. TST mm: ______________ ☐ Unknown

C2d. TST interpretation: ☐ Positive ☐ Negative ☐ Unknown

C2e. History of Previous Positive TST ☐

Interferon-Gamma Release Assay (IGRA)

C3a. Was IGRA administered? ☐ Yes ☐ No ☐ Unknown

If YES, C3b. Date collected: ___/___/______ ☐ Date unknown

C3c. IGRA brand: ☐ QuantiFERON® ☐ T-SPOT ☐ Other (specify):

C3d. Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Invalid ☐ Unknown

C3e. History of previous positive IGRA ☐

U.S Review of Pre-Immigration CXR

C4. Pre-immigration CXR available?

☐ Yes ☐ No ☐ Not Verifiable

C5. U.S. interpretation of pre-immigration CXR:

☐ Normal

☐ Abnormal (must select one below):

- ☐ Not consistent with active TB
- ☐ Non-cavitary, consistent with TB
- ☐ Cavitary, consistent with TB

☐ Poor Quality

☐ Unknown

U.S. Domestic CXR

C7. U.S. domestic CXR done?

☐ Yes ☐ No ☐ Unknown

If YES, C8. Date of U.S. CXR: ___/___/______

C9. Interpretation of U.S. CXR:

☐ Normal

☐ Abnormal (must select one below):

- ☐ Not consistent with active TB
- ☐ Non-cavitary, consistent with TB
- ☐ Cavitary, consistent with TB

☐ Unknown

Comparison

C11. U.S. domestic CXR comparison to pre-immigration CXR:

☐ Stable

☐ Worsening

☐ Improving

☐ Unknown

C6. Other pre-immigration CXR abnormalities:

☐ Volume loss ☐ Infiltrate ☐ Granuloma(ta)

☐ Adenopathy ☐ Other (specify)

C10. U.S. domestic CXR abnormalities:

☐ Volume loss ☐ Infiltrate ☐ Granuloma(ta)

☐ Adenopathy ☐ Other (specify)

U.S. Review of Pre-Immigration Treatment

C12a. Completed treatment pre-immigration? ☐ Yes ☐ No

If YES, ☐ Treated for TB disease ☐ Treated for LTBI

C12b. Treatment start date: ___/___/____ ☐ Start date unknown

C12c. Treatment end date: ___/___/____ ☐ End date unknown

C12d. Treatment reported by:

☐ Treatment documented on DS forms

☐ Patient reported treatment completion **at** or **before** panel physician examination

☐ Both-documented on DS forms & patient reported

☐ Unknown

C12e. Standard TB treatment regimen was administered?

☐ Yes ☐ No ☐ Unable to verify

C13. Arrived on treatment?

☐ Yes ☐ No ☐ Unknown

If YES, ☐ TB disease ☐ LTBI

C13a. Start date: ___/___/____ ☐ Start date unknown

C14: Pre-Immigration treatment concerns?

☐ Yes ☐ No

If YES,

☐ Treatment duration too short

☐ Incorrect treatment regimen

☐ Other, please specify:

Alien #	EDN TB Follow-Up Worksheet (Cont)	Last reviewed: 6/21/2013

C15. 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	___/___/_____	☐ Positive ☐ Negative ☐ Not Done ☐ Unknown	☐ NTM ☐ MTB Complex ☐ Contaminated ☐ Negative ☐ Not Done ☐ Unknown	☐ MDR-TB ☐ Mono-RIF ☐ Mono-INH ☐ Other DR ☐ No DR ☐ Not Done
2	___/___/_____	☐ Positive ☐ Negative ☐ Not Done ☐ Unknown	☐ NTM ☐ MTB Complex ☐ Contaminated ☐ Negative ☐ Not Done ☐ Unknown	☐ MDR-TB ☐ Mono-RIF ☐ Mono-INH ☐ Other DR ☐ No DR ☐ Not Done
3	___/___/_____	☐ Positive ☐ Negative ☐ Not Done ☐ Unknown	☐ NTM ☐ MTB Complex ☐ Contaminated ☐ Negative ☐ Not Done ☐ Unknown	☐ MDR-TB ☐ Mono-RIF ☐ Mono-INH ☐ Other DR ☐ No DR ☐ Not Done

D. Evaluation Disposition

D1. Evaluation disposition date: ___/____/______

D2. Evaluation disposition:

☐ Completed evaluation ☐ Initiated Evaluation / Not completed ☐ Did not initate evaluation

If evaluation was completed, was treatment recommended?

☐ Yes ☐ No

☐ LTBI

☐ Active TB

If evaluation was NOT completed, why not?

☐ Not Located ☐ Moved within U.S., transferred to:

☐ Lost to Follow-Up ☐ Moved outside U.S.

☐ Refused Evaluation ☐ Died

☐ Unknown ☐ Other, specify

D3. Diagnosis

☐ Class 0 - No TB exposure, not infected ☐ 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

D *If diagnosed with TB disease,* ☐ RVCT Reported D5. RVCT #: ☐ RVCT # unknown

E. U.S. Treatment

E1. U.S. treatment initiated: ☐ Yes ☐ No ☐ Unknown

*If **NO**, specify the reason:*

☐ Patient declined against medical advice ☐ Lost to follow-up ☐ Moved within U.S, tranferred to:

☐ Died ☐ Moved outside the U.S. ☐ Other (specify)

☐ Unknown

*If **YES**:* ☐ TB disease ☐ LTBI

E2. Treatment start date: ___/____/______

E3. U.S. treatment completed: ☐ Yes ☐ No ☐ Unknown

*If **NO**, specify the reason:*

☐ Patient stopped against medical advice ☐ Lost to follow-up ☐ Adverse effect

☐ Provider decision ☐ Moved outside the U.S. ☐ Moved within U.S, tranferred to:

☐ Died ☐ Unknown ☐ Other (specify)

If treatment was completed, E4. Treatment completion date: ___/____/______

If treatment was iniated but NOT completed, E5. Treatment end date: ___/____/______

F. Comments

G. Screen Site Information

Provider's Name:

Clinic Name:

Telephone Number: