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

A. Demographic

A1. Name (Last, First, Middle):	**A2. Alien #:**	**A3. Visa type:**	**A4. Initial U.S. entry date:**
A5. Age: / A6. Sex:	A7. DOB: ___/___/______	A8. TB Class Based on *Technical Instructions for Panel Physicians*:	

A9. Country of examination:

A10. Country of birth:

A11a. Name in care of:

A11b. Phone number:

A11c. Address:

A12a. Sponsor agency name:

A12b. Phone number:

A12c. Address:

B. Jurisdictional Information

B1. Arrival jurisdiction:

B2. Current jurisdiction:

C. U.S. Evaluation

C1. Date of first U.S. test or provider/clinic visit: ___/___/_____

Mantoux Tuberculin Skin Test (TST) in U.S.

C2a. Was a TST administered in the U.S.?

☐ Yes ☐ No ☐ Unknown

If ***YES***, C2b. TST placement date: ____/_____/__________

☐ Placement date uknown

C2c. TST mm: _____________ ☐ Unknown

C2d. TST interpretation:

☐ Positive ☐ Negative
☐ Unknown

C2e. History of Previous Positive TST:

☐ Yes ☐ No ☐ Unknown

Interferon-Gamma Release Assay (IGRA) in U.S.

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

If ***YES***, C3b. Date collected: ____/____/_____ ☐ Date unknown

________ IUs/Spots

C3c. IGRA brand:

☐ QuantiFERON® ☐ T-SPOT

☐ Other (specify): ___________________

C3d. Result: ☐ Positive ☐ Negative ☐ Indeterminate, Borderline, or Equivocal

☐ Invalid ☐ Unknown

C3e. History of previous positive IGRA:

☐ Yes ☐ No ☐ Unknown

U.S Review of Pre-Immigration CXR

C4. Pre-immigration CXR available?

☐ Yes ☐ No ☐ Unknown

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

☐ Normal (Negative for TB)
☐ Abnormal
- ☐ Suggestive of TB
- ☐ Non-TB Condition

☐ Poor Quality/Not Interpretable
☐ Unknown

U.S. Domestic CXR

C6a. U.S. domestic CXR done?

☐ Yes ☐ No ☐ Unknown

If ***YES***, C6b. Date of U.S. CXR: ___/___/_____

C7. Interpretation of U.S. CXR:

☐ Normal (Negative for TB)
☐ Abnormal
- ☐ Suggestive of TB
- ☐ Non-TB Condition

☐ Poor Quality/Not Interpretable
☐ Unknown

Comparison

C8. U.S. domestic CXR comparison to pre-immigration CXR:

☐ Stable
☐ Worsening
☐ Improving
☐ Unknown

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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	___/___/_____	☐ 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 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 initate 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

☐ Lost to Follow-Up

☐ Refused Evaluation

☐ Unknown

☐ Moved within U.S., transferred to:______________________ State/jurisdiction

☐ Moved outside U.S.

☐ Died

☐ 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

☐ Pulmonary ☐ Extra-pulmonary ☐ Both sites

☐ Class 4 - TB, inactive disease

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Alien #

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
- ☐ Died
- ☐ Currently on treatment
- ☐ Contraindication for treatment
- ☐ Lost to follow-up
- ☐ Moved outside the U.S.
- ☐ Treatment not offered based on local clinic guidelines
- ☐ Moved within U.S., transferred to:______________ State/jurisdiction
- ☐ Prior treatment completed (year: _________)
- ☐ Unknown
- ☐ 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
- ☐ Died
- ☐ Dying (treatment stopped because of imminent death, regardless of cause of death)
- ☐ Provider decision
- ☐ Lost to follow-up
- ☐ Moved outside the U.S.
- ☐ Adverse effect
- ☐ Not TB disease
- ☐ Pregnancy [For patient diagnosed with LTBI]
- ☐ Moved within U.S., transferred to:________ State/jurisdiction
- ☐ Unknown
- ☐ Other, specify: __________________
- ☐ Developed TB [For patient diagnosed with LTBI]

E6. Date therapy stopped: _____/_____/_________

Specify reason therapy stopped:____

F. Evaluation Site Information	**G. Treatment Site Information**
Provider's Name:	Provider's Name:
Clinic Name:	Clinic Name:
Telephone Number:	Telephone Number:
	☐ Same as evaluation site information

H. Comments