TUBERCULOSIS SURVEILLANCE SUMMARY RECORD

IDENTIFICATION INFORMATION

NAME (Last, first, middle initial)

❍ Employee
❍ Resident

DATE OF ADMISSION/ EMPLOYMENT — Month — Day — Year

DATE OF BIRTH — Month — Day — Year

SOCIAL SECURITY OR ID NUMBER

BASELINE ASSESSMENT FOR INCREASED RISK

Have you traveled to or lived for 1 month or longer in a country with a high TB rate (i.e., Mexico, SE Asia, Haiti, Guatemala, China, etc.) in the past year?

❍ No ❍ Yes, specify_____

Are you currently on immunosuppression medication, such as, chronic steroids (prednisone ≥ 15mg/day for ≥ 1 month) treatment with a TNF-alpha antagonist (i.e., infliximab, entanercept, etc.), HIV infection therapy or other immunosuppressive medication?

❍ No ❍ Yes, specify_____

Are you the recipient of an organ transplant?

❍ No ❍ Yes, specify_____

Have you had close contact with someone who has had infectious TB since your last TB test?

❍ No ❍ Yes, specify_____

BASELINE TESTING

PRIOR TESTING HISTORY

Type: ❍ Skin (Mantoux) ❍ Blood (IGRA)
Result: ❍ Positive ❍ Negative
Date: — Month — Day — Year

INITIAL MANTOUX TEST

Date Given: — Month — Day — Year
Location:_____ Lot #:_____
Date Read: — Month — Day — Year
Size: _____ mm
Was Therapy Recommended: ❍ No ❍ Yes, specify:
_____
Nurse Signature:_____

SECOND MANTOUX TEST (In approximately 1 week if initial test is negative)

Date Given: — Month — Day — Year
Location:_____ Lot #:_____
Date Read: — Month — Day — Year
Size: _____ mm
Was Therapy Recommended: ❍ No ❍ Yes, specify:
_____
Nurse Signature:_____

IGRA

Date of Blood Draw: — Month — Day — Year
❍ Negative ❍ Positive ❍ Uninterpretable

ALTERNATIVE TESTING

X-RAY

Date: — Month — Day — Year
Result: ❍ Normal ❍ Abnormal
If Abnormal: ❑ Cavitary ❑ Stable ❑ Non-Cavitary ❑ Worsening

HISTORY OF PREVIOUS TB TREATMENTS

❍ Infection Date: — Month — Day — Year
❍ TB Disease Date: — Month — Day — Year

BACTERIOLOGY FOR M. TUBERCULOSIS

Microscopy: ❍ Positive ❍ Negative
Culture: ❍ Positive ❍ Negative
Date Collected: — Month — Day — Year
Source:_____

DIAGNOSIS

Date: — Month — Day — Year
❍ Active TB ❍ TB Infection w/o Disease

ACTIVE TB

Major Site of Disease
❍ Pulmonary
❍ Other, specify_____

HEALTH DEPARTMENT REPORTING

Case Reported to Health Department:
❍ No ❍ Yes _____
Date of Report: — Month — Day — Year
Contact Investigation Done:
❍ No ❍ Yes _____

CHEMOTHERAPY (For infection or disease)

Drugs Recommended:_____
_____
_____
Date Drugs Started: — Month — Day — Year
Date Drugs Stopped: — Month — Day — Year
Reason:_____
Supervised By:_____
If Drugs Not Started, Give Reason:_____

HIV TEST (Voluntary)

Date: — Month — Day — Year
If Not Done, Give Reason:_____
_____
_____

Record Additional X-Rays and Bacteriology on the Reverse.

❑ Continued on Reverse

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ADDITIONAL SKIN TESTS

Date	Size/mm	Nurse Signature

ADDITIONAL BLOOD TESTS

Date	Results	Nurse Signature
	❍ Neg ❍ Pos ❍ Uninterpret	
	❍ Neg ❍ Pos ❍ Uninterpret	
	❍ Neg ❍ Pos ❍ Uninterpret	
	❍ Neg ❍ Pos ❍ Uninterpret	
	❍ Neg ❍ Pos ❍ Uninterpret	
	❍ Neg ❍ Pos ❍ Uninterpret	

ADDITIONAL X-RAY SCREENING

Date	Results

ADDITIONAL BACTERIOLOGY TESTING

Date Collected	Micros-copy	Culture	Source	Results

ADDITIONAL INFORMATION/COMMENTS