DEPARTMENT OF HEALTH
TUBERCULOSIS CASE REPORT

Name: **SSN#** **Date of Report:**

Address: **Telephone#** **Date of Birth**

Marital Status:	**Sex:**	**Race:**	**Country of Origin if not U.S.**
☐Single ☐Married ☐Divorced ☐Separated ☐Widowed	☐Female ☐Male	☐Black ☐American Indian or Alaskan Native ☐White ☐Asian or Pacific Islander **Ethnic Origin:** ☐Hispanic ☐Not Hispanic ☐Define: ___________	______________________ **Date arrived in the U.S.** ______________________

Occupation **Place of Employment** **Address**

Classification	Diagnosis	Bacteriology
☐Tuberculosis current disease ☐Tuberculosis no current disease ☐Tuberculosis suspect ☐Tuberculosis infection no disease Signs and Symptoms: ______________________ ______________________	☐Pulmonary ☐Non-Pulmonary ☐Miliary ☐Meningitis ☐Bones and Joints ☐Pleural ☐Lymphatic ☐Peritoneal ☐Genitourinary ☐Other (specify): ☐Reported at time of death Immunocompromised ☐Neg. ☐Pos.	POS. / NEG. / Pending / Not Done Smear ☐ ☐ ☐ ☐ Culture ☐ ☐ ☐ ☐ Type of Specimen: ☐Sputum ☐Fluid ☐Tissue ☐Other (specify) ______________________ ______________________ Date(s) of collection ______________________ Laboratory Performed

Chest X-ray	Tuberculin Skin Test	Chemotherapy Dosage
☐Not done ☐Normal ☐Abnormal ☐Cavitary ☐Non-Cavitary ☐Stable ☐Worsening ☐Improving ________________ Date of X-Ray	☐Not done ☐QuantiFERON ☐T-spot ☐Mantoux ☐Tine ☐Other (specify): _________________ ☐Significant Size (mm): ___________ ☐Not significant _________________ Date Read	☐Isoniazid ☐Rifampin ☐Ethambutol ☐Pyrazinamide ☐Streptomycin ☐Other (specify): _______________________ ____________________ Date started

Patient to be followed by:
Name:
Address: Phone:

Previous Diagnosis:
☐Yes ☐No
Date: ______________

Comments:

☐Send Additional Report Forms

Hospitalization
Chart No.:
Admission Date:
Discharge Date:

Reported by:		Signature		Office or Hospital Address	
Source#	Ward	Census Tract	Date Received	Case#	Verified

Please FAX TB Case Report to (202) 724-2363 Attn: Registry

Revised May 1, 2018