



NOTIFIABLE DISEASE REPORT FOR TUBERCULOSIS

Hawaii State Department of Health
Tuberculosis Control Program

MAIL OR FAX TO:
Hawaii Tuberculosis Control Program
ATTN: TB REGISTRY DEPARTMENT
1700 Lanakila Avenue, Honolulu, HI 96817
FAX: (808) 832-5624 PHONE: (808) 832-5731

1. Name: _____
LAST FIRST MIDDLE INITIAL

2. Address: _____
STREET NUMBER and STREET NAME

CITY, STATE, and ZIP CODE

3. Homeless Within Past Year: No Yes Unknown

4. Home Phone: _____ Cellular: _____ Work: _____

5. Next of Kin: _____ Relationship: _____ Phone: _____

6. Date of Birth: ____ / ____ / ____
MM DD YYYY

7. SSN (LAST 4 DIGITS):

8. Sex at Birth : Male Female

9. U.S. Citizen: No Yes Unknown

10. Place of Birth: _____

11. Foreign Born: _____
 Date Arrived in U.S.: ____ / ____ / ____

12. Primary Occupation Within the Past Year (SELECT ONE): Unknown Other (SPECIFY): _____

Unemployed Health Care Worker Correctional Facility Employee

Retired Migrant/Seasonal Worker Not Seeking Employment (E.G., INFANT, CHILD, STUDENT, HOMEMAKER, DISABLED PERSON)

13. Race / Ethnicity (CHECK ALL THAT APPLY):

African American Carolinian Chinese Guamanian Japanese Marshallese Palauan Tongan

Alaskan Native Caucasian Chuukese Hawaiian Korean Micronesian Pohnpeian Vietnamese

American Indian Chamorro Filipino Hispanic Kosraean Okinawan Samoan Yapese

Other (SPECIFY): _____

14. Reason Evaluated for TB (SELECT ONE): TB Symptoms Abnormal Chest Radiograph (Incidental Finding)

TB Contact Investigation Health Care Worker Screening DOH Mandated TB Screening (CATEGORY): _____

Immigration Medical Exam Lab Result (Incidental Finding) Other (SPECIFY): _____

15. Date of Diagnosis: ____ / ____ / ____
 Suspect Confirmed

16. Status at Diagnosis of TB:
 Alive Dead
 Date of Death: ____ / ____ / ____

17. Previous TB Disease
 No Yes
 IF YES, Enter Year of Previous TB Disease:

18. Site(s) of TB Disease (CHECK ALL THAT APPLY): Lymphatic: Unknown

Pulmonary Lymphatic: Intrathoracic Bone AND/OR Joint

Pleural Lymphatic: Cervical Genitourinary

Laryngeal Lymphatic: Axillary Peritoneal

Meningeal Lymphatic: Other Other: _____

19. Bacteriology	DATE COLLECTED	SPECIMEN TYPE & SITE (E.G., SPUTUM, TISSUE, PLEURAL FLUID, ETC.)	SMEAR RESULT IF POSITIVE, ENTER SMEAR COUNT (E.G., 1+, 2+, 3+, 4+)	NUCLEIC ACID AMPLIFICATION (E.G., MTD DIRECT)	CULTURE	DRUG SUSCEPTIBILITY RESULTS IF CULTURE POSITIVE FOR MTB, INDICATE DRUG RESISTANCE
	/ /	Type: Site:	<input type="checkbox"/> NEG <input type="checkbox"/> POS ____ <input type="checkbox"/> PENDING	<input type="checkbox"/> NEG <input type="checkbox"/> POS <input type="checkbox"/> PEND <input type="checkbox"/> INDET	<input type="checkbox"/> PEND <input type="checkbox"/> NEG <input type="checkbox"/> MTB COMPLEX <input type="checkbox"/> NOT TB (SPECIFY ID): _____	<input type="checkbox"/> PEND <input type="checkbox"/> PAN SUSCEPTIBLE <input type="checkbox"/> RESISTANT TO: _____
	/ /	Type: Site:	<input type="checkbox"/> NEG <input type="checkbox"/> POS ____ <input type="checkbox"/> PENDING	<input type="checkbox"/> NEG <input type="checkbox"/> POS <input type="checkbox"/> PEND <input type="checkbox"/> INDET	<input type="checkbox"/> PEND <input type="checkbox"/> NEG <input type="checkbox"/> MTB COMPLEX <input type="checkbox"/> NOT TB (SPECIFY ID): _____	<input type="checkbox"/> PEND <input type="checkbox"/> PAN SUSCEPTIBLE <input type="checkbox"/> RESISTANT TO: _____
	/ /	Type: Site:	<input type="checkbox"/> NEG <input type="checkbox"/> POS ____ <input type="checkbox"/> PENDING	<input type="checkbox"/> NEG <input type="checkbox"/> POS <input type="checkbox"/> PEND <input type="checkbox"/> INDET	<input type="checkbox"/> PEND <input type="checkbox"/> NEG <input type="checkbox"/> MTB COMPLEX <input type="checkbox"/> NOT TB (SPECIFY ID): _____	<input type="checkbox"/> PEND <input type="checkbox"/> PAN SUSCEPTIBLE <input type="checkbox"/> RESISTANT TO: _____
	/ /	Type: Site:	<input type="checkbox"/> NEG <input type="checkbox"/> POS ____ <input type="checkbox"/> PENDING	<input type="checkbox"/> NEG <input type="checkbox"/> POS <input type="checkbox"/> PEND <input type="checkbox"/> INDET	<input type="checkbox"/> PEND <input type="checkbox"/> NEG <input type="checkbox"/> MTB COMPLEX <input type="checkbox"/> NOT TB (SPECIFY ID): _____	<input type="checkbox"/> PEND <input type="checkbox"/> PAN SUSCEPTIBLE <input type="checkbox"/> RESISTANT TO: _____

20. Tuberculin Skin Test (TST) at Diagnosis: Not Done

Negative -- Date TST Placed: ____ / ____ / ____ Induration: ____ mm

Positive -- Date TST Placed: ____ / ____ / ____ Induration: ____ mm

21. Interferon Gamma Release Assay (IGRA) (E.G., QUANTIFERON AND T-SPOT.TB):

Not Done Negative Positive Indeterminate

Date Collected: ____ / ____ / ____ Type of IGRA (SPECIFY): _____

Patient Name: _____ **Date of Birth:** ____/____/____
LAST FIRST MIDDLE INITIAL MM DD YYYY

22. Date of 1st Chest Radiograph: ____/____/____
 Check One: Abnormal Normal Not Done
 IF Abnormal: Evidence of Cavity: No Yes Unknown
 Evidence of Miliary TB: No Yes Unknown

23. Date of 2nd Chest Radiograph: ____/____/____
 Check One: Stable Worsening Improving

24. Date of 1st Chest CT Scan or Other Chest Imaging: ____/____/____
 Check One: Abnormal Normal Not Done
 IF Abnormal: Evidence of Cavity: No Yes Unknown
 Evidence of Miliary TB: No Yes Unknown

25. Date of 2nd Chest CT Scan or Other Chest Imaging: ____/____/____
 Check One: Stable Worsening Improving

26. Date Therapy Started: ____/____/____
 Therapy Not Started

27. Patient on Directly Observed Therapy (DOT):
 No Yes Unknown

28. Patient's Weight at Diagnosis: _____(kg)

29. Initial Drug Regimen and Frequency:

Levofloxacin	_____mg	_____times/week
Isoniazid	_____mg	_____times/week
Rifampin	_____mg	_____times/week
Pyrazinamide	_____mg	_____times/week
Ethambutol	_____mg	_____times/week
Moxifloxacin	_____mg	_____times/week
Ofloxacin	_____mg	_____times/week
(OTHER DRUG USED)	_____mg	_____times/week
(OTHER DRUG USED)	_____mg	_____times/week

30. HIV Status at Time of Diagnosis (SELECT ONE): Negative Positive Refused
 Indeterminate Not Offered Test Done, Results Unknown Unknown

31. HIV Antibody Test Date: ____/____/____

32. Excess Alcohol Use Within Past Year:
 No Yes Unknown

33. Injecting Drug Use Within Past Year:
 No Yes Unknown

34. Non-Injecting Drug Use Within Past Year:
 No Yes Unknown

35. Resident of Correctional Facility at Time of Diagnosis: No Yes Unknown
 IF YES, (SELECT ONE): Federal Prison State Prison Local Jail Juvenile Correctional Facility Unknown
 Other Correctional Facility (SPECIFY): _____

36. Resident of Long-Term Care Facility at Time of Diagnosis: No Yes Unknown
 IF YES, (SELECT ONE): Nursing Home Alcohol or Drug Treatment Facility Residential Facility Unknown
 Hospital-Based Facility Mental Health Residential Facility Other (SPECIFY): _____

37. Additional TB Risk Factors (SELECT ALL THAT APPLY): None Other (SPECIFY): _____

<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Contact of Infectious TB Patient (2 YEARS OR LESS)	<input type="checkbox"/> Post-Organ Transplantation
<input type="checkbox"/> End-Stage Renal Disease	<input type="checkbox"/> Contact of MDR TB Patient (2 YEARS OR LESS)	<input type="checkbox"/> Immunosuppression (NOT HIV/AIDS)
<input type="checkbox"/> Incomplete LTBI Treatment	<input type="checkbox"/> Missed Contact (2 YEARS OR LESS)	<input type="checkbox"/> TNF- α Antagonist Therapy (E.G., HUMIRA, REMICADE, AND ENBREL)

38. Date Reported: ____/____/____
 Reported By: _____
 Name of Institution: _____
 Address: _____
STREET NUMBER and STREET NAME

CITY, STATE, and ZIP CODE
 Work: _____ Cell: _____
 Pager: _____ Fax: _____
 Email Address: _____

39. Hospital Admission Date: ____/____/____
40. Hospital Discharge Date: ____/____/____

41. Name of Primary Care Physician: _____
 Phone Number: _____

42. Will the Patient Be Referred to the Hawaii Department of Health for TB Care?

Yes - For TB treatment and DOT (call DOH to initiate referral)
 Yes - For DOT only (call DOH to initiate referral)
 No - If patient is not referred to DOH, the physician treating TB must complete a TB follow-up report every 2 months to DOH.

◆ Name of Physician Treating TB: _____
 ◆ Phone Number: _____

43. Additional Notes/Remarks:

44. DOH USE ONLY

CC# / MR#: _____
 TB Class: _____
 CCMD: _____
 Nurse Case Manager: _____