State of Hawaii TB Document K:
NOTIFIABLE DISEASE REPORT FOR TUBERCULOSIS

Hawaii State Department of Health
Tuberculosis Control Program

FAX TO:
Hawaii Tuberculosis Control Program
ATTN: TB REGISTRY SECTION
1700 Lanakila Avenue, Honolulu, HI 96817
FAX: (808) 832-5624 PHONE: (808) 832-3534

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. Sex at Birth : ☐ Male ☐ Female

8. U.S. Citizen: ☐ No ☐ Yes ☐ Unknown

9. Place of Birth: __________________________

10. Foreign Born:

Date Arrived in U.S.: _____/_____/__________

11. 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)

12. 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): ____

13. 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): ______________________________

14. Date of Diagnosis: _____/_____/__________

☐ Suspect ☐ Confirmed

15. Status at Diagnosis of TB:

☐ Alive ☐ Dead

Date of Death: _____/_____/__________

16. Previous TB Disease

☐ No ☐ Yes

IF YES, Enter Year of Previous TB Disease: ☐☐☐☐

17. Site(s) of TB Disease (CHECK ALL THAT APPLY):

☐ Pulmonary ☐ Lymphatic: Intrathoracic ☐ Lymphatic: Unknown

☐ Pleural ☐ Lymphatic: Cervical ☐ Bone AND/OR Joint

☐ Laryngeal ☐ Lymphatic: Axillary ☐ Genitourinary

☐ Meningeal ☐ Lymphatic: Other ☐ Peritoneal

☐ Other: _______________

18. 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:	☐ NEG ☐ POS ____ ☐ PENDING	☐ NEG ☐ POS ☐ PEND ☐ INDET	☐ PEND ☐ NEG ☐ MTB COMPLEX ☐ NOT TB (SPECIFY ID): ____________	☐ PEND ☐ PAN SUSCEPTIBLE ☐ RESISTANT TO: __________
/ /	Type: Site:	☐ NEG ☐ POS ____ ☐ PENDING	☐ NEG ☐ POS ☐ PEND ☐ INDET	☐ PEND ☐ NEG ☐ MTB COMPLEX ☐ NOT TB (SPECIFY ID): ____________	☐ PEND ☐ PAN SUSCEPTIBLE ☐ RESISTANT TO: __________
/ /	Type: Site:	☐ NEG ☐ POS ____ ☐ PENDING	☐ NEG ☐ POS ☐ PEND ☐ INDET	☐ PEND ☐ NEG ☐ MTB COMPLEX ☐ NOT TB (SPECIFY ID): ____________	☐ PEND ☐ PAN SUSCEPTIBLE ☐ RESISTANT TO: __________
/ /	Type: Site:	☐ NEG ☐ POS ____ ☐ PENDING	☐ NEG ☐ POS ☐ PEND ☐ INDET	☐ PEND ☐ NEG ☐ MTB COMPLEX ☐ NOT TB (SPECIFY ID): ____________	☐ PEND ☐ PAN SUSCEPTIBLE ☐ RESISTANT TO: __________

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

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

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

20. 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

21. 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

22. Date of 2nd Chest Radiograph: _____/_____/_____
Check One: ☐ Stable ☐ Worsening ☐ Improving

23. 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

24. Date of 2nd Chest CT Scan or Other Chest Imaging: _____/_____/_____
Check One: ☐ Stable ☐ Worsening ☐ Improving

25. Date Therapy Started: _____/_____/_____
☐ Therapy Not Started

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

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

28. Initial Drug Regimen and Frequency:

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

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

30. HIV Antibody Test Date: _____/_____/_____

31. Excess Alcohol Use Within Past Year: ☐ No ☐ Yes ☐ Unknown

32. Injecting Drug Use Within Past Year: ☐ No ☐ Yes ☐ Unknown

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

34. 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): _____

35. 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): _____

36. Additional TB Risk Factors (SELECT ALL THAT APPLY): ☐ None ☐ Other (SPECIFY): _____
☐ Diabetes Mellitus ☐ Contact of Infectious TB Patient (2 YEARS OR LESS) ☐ Post-Organ Transplantation
☐ End-Stage Renal Disease ☐ Contact of MDR TB Patient (2 YEARS OR LESS) ☐ Immunosuppression (NOT HIV/AIDS)
☐ Incomplete LTBI Treatment ☐ Missed Contact (2 YEARS OR LESS) ☐ TNF-α Antagonist Therapy (E.G., HUMIRA, REMICADE, AND ENBREL)

37. Date Reported: _____/_____/_____
Reported By: _____
Name of Institution: _____
Address: _____
STREET NUMBER and STREET NAME
_____
CITY, STATE, and ZIP CODE
Work: _____ Cell: _____
Pager: _____ Fax: _____
Email Address:

38. Hospital Admission Date: _____/_____/_____

39. Hospital Discharge Date: _____ / _____ / _____

40. Name of Primary Care Physician:
Phone Number:

41. 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:

42. Additional Notes/Remarks:

43. DOH USE ONLY
CC# / MR#:
TB Class:
TBCMD:
Nurse Case Manager: