



Tuberculosis Branch Cohort Review Presentation Form

Quarter: <input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	Cohort Year:	Presentation Date:
Primary Case Manager:	Contact Investigator:	Treating Physician:
Section 1: Patient Information		
RVCT #:	Date of Birth:	
Patient Name:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date Case was Counted:	Country of Birth:	
Medical Risks (check all that apply): <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Recent Exposure to TB <input type="checkbox"/> Cancer of Neck <input type="checkbox"/> Alcohol Abuse (within past year) (contact to TB case) <input type="checkbox"/> Drug Abuse within Past Year <input type="checkbox"/> Tobacco Use <input type="checkbox"/> Contact to MDR-TB <input type="checkbox"/> TB Test Conversion in Last 2 Years <input type="checkbox"/> Silicosis <input type="checkbox"/> Weight at Least 10% Less Than Ideal Body Weight <input type="checkbox"/> Fibrotic Lesions (on chest X-ray) Consistent with Old, Healed TB <input type="checkbox"/> Corticosteroids or Other Immunosuppressive Therapy <input type="checkbox"/> Chronic Malabsorption Syndromes <input type="checkbox"/> Chronic Renal Failure <input type="checkbox"/> Gastrectomy or Jejunioileal Bypass <input type="checkbox"/> Leukemia <input type="checkbox"/> Organ Transplant <input type="checkbox"/> Age < 5 Years <input type="checkbox"/> Lymphoma <input type="checkbox"/> Other: _____ <input type="checkbox"/> Cancer of Head		
Code 900: <input type="checkbox"/> Not Offered <input type="checkbox"/> Refused Collection Date: _____ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending CD4 Count, if positive:		
Section 2: Diagnostic Information		
Disease Site:	Initial Chest X-ray Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Abnormal/Cavitary <input type="checkbox"/> Not Done	
Collection Date of Initial Positive AFB Smear:	Collection Date of Initial Positive MTB Culture:	
Resistance: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Resistant to:		
Section 3: Treatment Completion Information		
Treatment Start Date:	Treatment Completion Date:	
Collection Date of First Consistently Negative AFB Smear:	Collection Date of First Consistently Negative MTB Culture:	
If Treatment Not Completed, check all that apply: <input type="checkbox"/> Still on Therapy (Planned Completion Date: _____) <input type="checkbox"/> Treatment Interruption (<input type="checkbox"/> Adverse Reaction <input type="checkbox"/> Patient Non-adherence <input type="checkbox"/> Provider Decision) <input type="checkbox"/> MDR <input type="checkbox"/> Refused (Reason: _____) <input type="checkbox"/> Lost <input type="checkbox"/> Died (Date: _____) <input type="checkbox"/> Reported at Death <input type="checkbox"/> Moved out of Country (To: _____) <input type="checkbox"/> Inter-jurisdictional Transfer (To: _____ Date: _____) <input type="checkbox"/> Other:		
If Not on DOT Explain: Number of Recommended Doses: Number of Doses Taken:		

Section 4: Contact Investigation Results

Genotyped: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, GENType:	
Number of Contacts Identified:	Number of Contacts Evaluated:
Number of Documented Prior Positives:	
Number of Contacts Infected <u>without</u> TB Disease:	
Number of Contacts Identified as AFB Smear Positive:	
Number of Contacts Identified with TB Disease:	
Number of Contacts Eligible for Treatment of TB Infection (TBI):	
Number of Contacts that Started Treatment for TBI: Recent Documented Conversions: _____ Children ≤ 5 Years: _____ Known HIV+ Status: _____	
Number of Contacts Currently on Treatment for TBI:	
Number of Contacts that Completed Treatment for TBI: Recent Documented Conversions: _____ Children ≤ 5 Years: _____ Known HIV+ Status: _____	
Number of Contacts that Did Not Complete Treatment for TBI Due To: _____ Still on Treatment _____ Adverse Reactions _____ Died _____ Moved _____ Refused _____ Lost _____ Provider Decision (Unable to Monitor Patient Care) _____ Other:	
Percentage of Contacts Infected: (Formula: $\frac{\text{Number of Contacts Infected} - \text{Prior Positives}}{\text{Number Evaluated} - \text{Prior Positives}} \times 100\%$)	