TEXAS Health and Human Services

Texas Department of State Health Services

TEXAS HANSEN'S DISEASE PROGRAM C-12
SURVEILLANCE FORM AND TEXAS CASE REPORT

1. Reporting State:	2. Date of Report:	3. Last 4 digits of Social Security Number (optional):

4. Patient Name:
(Last) *(First)* *(Middle)*

5. Home/Present Address: Street City County

State Zip Email Address: Phone #

6. Place of Birth: City State Country	7. Date of Birth: Mo. Day Yr.

8. Ethnicity: ☐ Non-Hispanic ☐ Hispanic or Latino

Race: ☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ White

9. Primary Language:
☐ English ☐ Spanish
☐ Other:

10. Date entered U.S.:	11. Date of onset of symptoms:	12. Date HD first diagnosed:	13. Patient Sex: ☐M ☐F	14. Is patient receiving assistance through local, state, or federal programs for disability? ☐ Y ☐ N ☐ Unknown

15. List all places the PATIENT has ever lived *(Including Military Service)* BEFORE leprosy was diagnosed:

TOWN	COUNTY	STATE	COUNTRY	INCLUSIVE DATES	
				From: Mo./Yr.	To: Mo./Yr.

16. Type of Leprosy: *(ICD-10-CM Code)*

☐ Tuberculoid A30.1 (TT) ☐ Borderline Tuberculoid A30.2 (BT) ☐ Indeterminate A30.0 (IN)

☐ Borderline A30.3 (BB) ☐ Borderline Lepromatous A30.4 (BL) ☐ Lepromatous Leprosy A30.5 (LL)

☐ Other Specified Leprosy A30.8 ☐ Leprosy Unspecified A30.9

17. Diagnosis of Disease:

Was initial diagnosis done: ☐ In the U.S. ☐ Outside of the U.S.

Immunological reaction at diagnosis? ☐ Yes ☐ No

Was biopsy performed? ☐ Yes ☐ No **PCR**: Positive ☐ Negative ☐

18. Treatment: Start Date: _____ Treatment end date: _____	19. Current antibiotics for Leprosy: (check all that apply) ☐ Rifampin ☐ Moxifloxacin ☐ Minocycline ☐ Dapsone ☐ Clofazimine ☐ Others: _____

20. Name of person filling out the form: _____

Phone Number: _____ Fax Number: _____

Email address: _____

Treating Physician/Provider: _____

Name (Last, First): _____ *DOB:* _____

21. Aliases:		**22. Phone Number(s):**	
23. Entered Texas: Date: From Where:	**24. Citizen of:**	**25. Education Level:**	**26. Employment:**

27. Health Insurance:

☐ Medicare ☐ Medicaid ☐ BC/BS ☐ Private Insurance ☐ None

28. Armadillo Contact? ☐ Yes ☐ No ☐ Unknown

Describe:

29. Date of Onset of Symptoms: ☐☐/ ☐☐ / ☐☐

Give Brief Description & History Prior to Diagnosis:

30. Diagnosing Physician Information (indicate Yes or No if this is also the treating physician): ☐ Yes ☐ No

Name: _____

Address: _____

City: _____

Phone: _____

31. Known Contact with Hansen's Disease Case? ☐ Yes ☐ No ☐ Unknown

(If answered Yes to #32) Name of Suspected Source	DOB	Sex	Relationship	Household Contact	Inclusive Dates of Contact

Name (Last, First): _____ ***DOB:*** _____

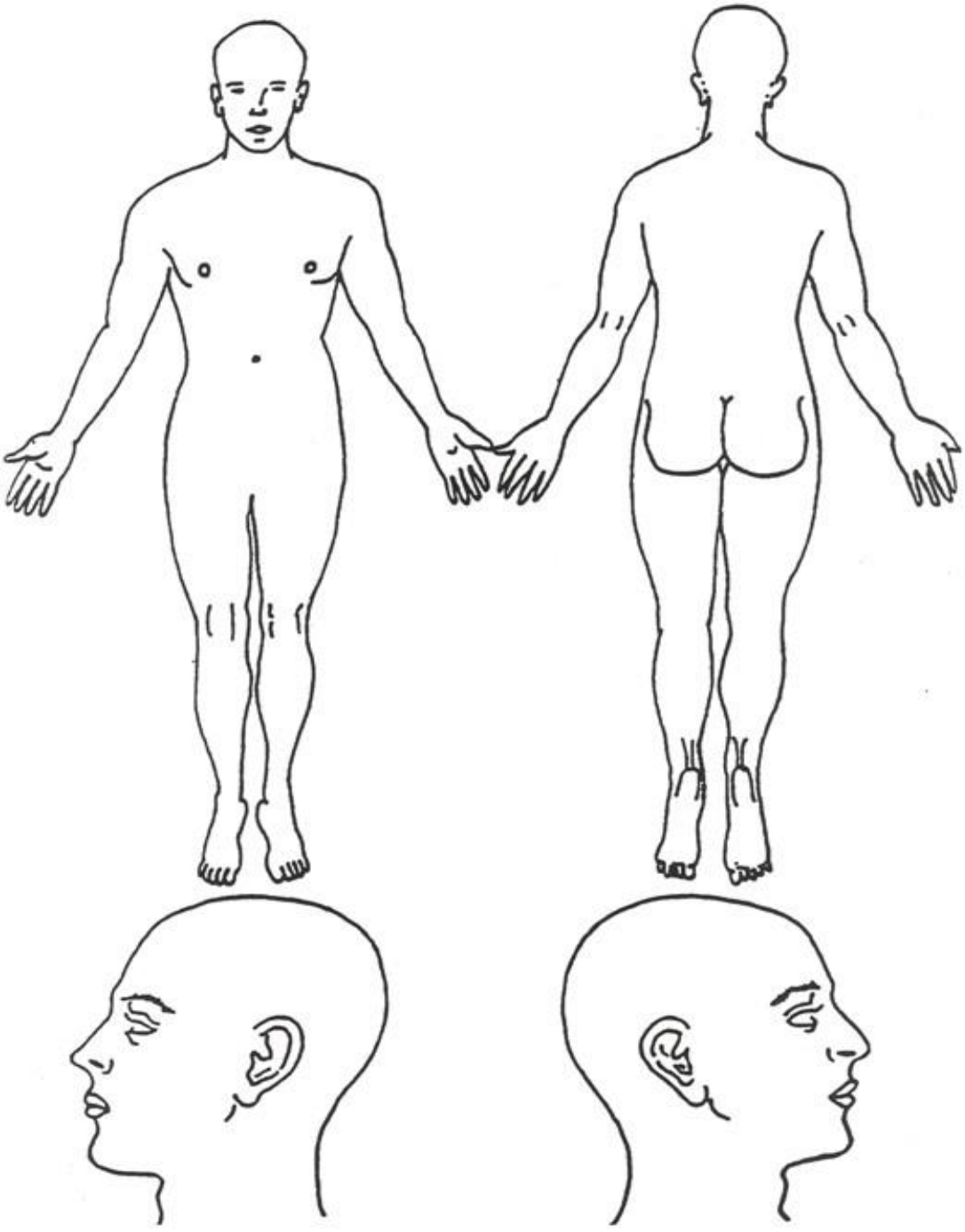
32. Contact Surveillance: If not listed on page 2 #32, or when more details are needed for the Follow-up. *A contact is any individual who has shared the same enclosed air space in a household or other enclosed environment for a prolonged period with a person who has an untreated case of HD.*

Name Relation to Index	DOB	Inclusive Contact Dates From MM/YY	 To MM/YY	Address	Follow-up: Date and Status, if contact was assessed in clinic C = Case N = Negative, no signs/symptoms S = Suspicious Lesions

Name (Last, First): _____ *DOB:* _____

33. Date of Examination: ☐☐ ☐☐ ☐☐

(Mark on the below pictures any physical findings suggestive of Hansen's Disease)



Instructions for Completing the Hansen's Disease (Leprosy) C-12 Surveillance Form

Fill out all surveillance data and patient information, and send to the Texas Department of State Health Services (DSHS) within 3 days. Page 1 is the National Hansen's Disease (NHDP) Surveillance Form, pages 2-4 are required for Texas reporting, pages 5-6 are instructions. Contact DSHS at 737-255-4300 for questions regarding reporting HD in Texas.

ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL

1. **Reporting State:** Use the abbreviation of the state from which the report is being sent. This is usually the state of the clinician's office and not necessarily the patient's resident state.
2. **Date of Report:** This is date of the initial LSF completion. If patient was previously reported and has relapsed, write the word "RELAPSE" next to the date.
3. **Social Security Number (last 4):** Optional; self-explanatory.
4. **Patient Name:** Self-explanatory.
5. **Home/Present Address:** Please include the county and zip code which are used to geographically cluster patients.
6. **Place of Birth:** Include state and city, if born in the U.S., or the country, if foreign born.
7. **Date of Birth:** Self-explanatory.
8. **Race/Ethnicity:** This information should be voluntarily provided by the patient. If the patient refuses or indicates a race/ethnicity category not listed, check the "Not Specified" box.
9. **Primary Language:** Patient's primary language preference.
10. **Date Entered the U.S.:** For patients who have immigrated to the U.S., provide the month and year of entry.
11. **Date of Onset of Symptoms:** This information is usually the patient's recollection of when classic leprosy symptoms *(rash, nodule formation, paresthesia, decreased peripheral sensation, etc.)* were first noticed.
12. **Date Leprosy First Diagnosed:** Provide the month and year a diagnosis was made. This usually coincides with a biopsy date if one was performed.
13. **Patient Sex:** Sex of patient. M = Male, F = Female.
14. **Disability Assistance:** Is patient receiving any government assistance through local, state or federal programs for disability?
15. **Residence (Pre-diagnosis):** List all cities, counties, and states in the U.S. and all foreign countries a patient resided in BEFORE leprosy was diagnosed. This information is used to map all places where U.S. leprosy cases have resided.
16. **Type of Leprosy:** Classify the diagnosis based on one of the ICD-10-CM diagnosis codes. (NHDP Clinic physicians: Please circle specific classification, if possible). RJ = Ridley-Jopling
    a. **A30.1 Tuberculoid Leprosy (macular, maculoanesthetic, major, minor, neuritic – includes RJ Tuberculoid [TT] and A30.2 Borderline tuberculoid [BT]*)*:** A form marked by usually one lesion with well-defined margins with scaly surface and local tender cutaneous or peripheral nerves.
    b. **A30.0 Indeterminate (uncharacteristic, macular, neuritic):** A form marked by one or more macular lesions, which may have slight erythema.
    c. **A30.3 Borderline (dimorphous, infiltrated, neuritic – includes RJ Borderline [BB] or true mid disease only):** A form marked by early nerve involvement and lesions of varying stages.
    d. **A30.5 Lepromatous Leprosy (macular, diffuse, infiltrated, nodular, neuritic – includes RJ Lepromatous [C] and A30.4 Borderline lepromatous [BL]):** A form marked by erythematous macules, generalized papular and nodular lesions, and variously by upper respiratory infiltration, nodules on conjunctiva or sclera, and motor loss.
    e. **A30.8 Other Specified Leprosy:** Use this code when the diagnosis is specified as "leprosy" but is not listed above (A30.0-A30.3), including 'pure neural' disease.
    f. **A30.9 Leprosy, Unspecified:** Use this code when the diagnosis is identified as "leprosy" but inactive.
17. **Diagnosis of the Disease:** Self-explanatory. Was the patient in immunological reaction at diagnosis? Biopsy and PCR done?
18. **Treatment:** Start date and end date (if completed treatment).
19. **Current Treatment for Leprosy:** Date that treatment started and indicate all drugs used for initial treatment.

Instructions (Continued)

20. - 30. **Self-explanatory.**

31. **Known Contact with Hansen's Disease Case:** Indicate if patient is a contact to someone with diagnosed Hansen's Disease. If yes, include suspected source information.

32. **Contact Surveillance:** For contacts not listed on page 1, or when more information is known regarding the status of the contact, list all requested fields.

33. **Date of Examination:** Date of physical exam by physician or HD clinic. Mark/draw on the body part to indicate where signs or symptoms of leprosy occur (rash, nodule formation, paresthesia, decreased peripheral sensation, etc.).