TEXAS Health and Human Services | Texas Department of State Health Services

Tuberculosis (TB) Incident Report

Complete this form to report any of the following events: media sensitive exposures, exposures with ≥ 50 contacts in a single site, child daycare or K-12 school exposures with ≥ 25 contacts, or any other exposures deemed concerning by the program. Please attach the form to the NEDSS investigation and send email notification to TBEpi@dshs.texas.gov within 48 hours of incident. Fields may be left blank if information is pending.

Incident Reports involving exposures in a correctional facility should be submitted using the form 12-12063.

A. Incident Report Information	
Submission Date:	**Local Contact Person:**
City of Incident:	**Title:**
County of Incident:	**Phone Number:**
Public Health Jurisdiction:	**Email:**
Location of Concerning Exposure:	

B. Suspected or Confirmed Case Information			
Patient Name:		**TST Performed?** ☐ Yes ☐ No ☐ Unknown	
DOB:	**NEDSS Investigation ID:**	TST Date Placed:	TST Date Read:
Gender: ☐ Male ☐ Female ☐ Other:		Results (mm):	☐ Positive ☐ Negative
Country of Birth:		**IGRA Result:** ☐ Positive ☐ Negative ☐ Pending ☐ Indeterminate/Borderline ☐ Not Performed	
If not U.S., Arrival Date:			
Symptom Onset Date:		IGRA Test Date:	
☐ Cough ☐ Chills ☐ Hemoptysis ☐ Fever ☐ Fatigue ☐ Loss of appetite ☐ Night Sweats ☐ Weight Loss ☐ Other, please specify:		IGRA Test Type: ☐ T-SPOT ☐ QFT ☐ Unknown	
		AFB Specimen Site:	
		Collection Date:	
Symptom End Date:		Specimen sent to DSHS? ☐ Yes ☐ No ☐ Unknown	
Hospitalized? ☐ No ☐ Yes, Dates: _____ to _____		**AFB Sputum Smear Result:** ☐ Positive ☐ Negative ☐ Pending ☐ Not Performed	
Name of Hospital:			
Infectious? ☐ No ☐ Yes, Dates: _____ to _____		**NAAT Result:** ☐ Positive ☐ Negative ☐ Pending ☐ Not Performed	
If yes, isolated? ☐ Yes ☐ No			
Started on Treatment? ☐ Yes ☐ No ☐ Unknown		**AFB Culture Result:** ☐ Positive ☐ Negative ☐ Pending ☐ Not Performed	
Start Date:	End Date:		
Started on RIPE? ☐ Yes ☐ No ☐ Unknown		**Chest Imaging Performed?** ☐ Yes ☐ No ☐ Unknown	
If not RIPE, specify regimen:		Chest Imaging Type:	
Case Died? ☐ No ☐ Yes, Date of Death:		Date:	Results: ☐ Normal ☐ Abnormal
Was TB diagnosed at death? ☐ Yes ☐ No ☐ Unknown		Cavitary? ☐ Yes ☐ No	Miliary? ☐ Yes ☐ No
Was TB cause of death? ☐ Yes ☐ No ☐ Unknown			
Comments:			

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C. Exposure Location Information			
Site Name:		Site Location:	
Exposure Dates:	**Site Visit Performed**: ☐ Yes ☐ No		**Site Visit Date**:
Site Type: ☐ Child Daycare ☐ K-12 School ☐ College/University ☐ Homeless Shelter/Group Home ☐ Nursing Home/Hospice ☐ Long-term Care Facility ☐ Assisted Living/Adult Daycare ☐ Outpatient Medical Facility ☐ Hospital/Inpatient Medical Facility ☐ Other, specify:			
#High Priority:	#Medium Priority:	#Low Priority:	Total # Contacts:
Please describe site environment(s) (i.e. large vs. small room, ventilation details, etc.)			
Site Name:		**Site Location:**	
Exposure Dates:	**Site Visit Performed:** ☐ Yes ☐ No		**Site Visit Date:**
Site Type: ☐ Child Daycare ☐ K-12 School ☐ College/University ☐ Homeless Shelter/Group Home ☐ Nursing Home/Hospice ☐ Long-term Care Facility ☐ Assisted Living/Adult Daycare ☐ Outpatient Medical Facility ☐ Hospital/Inpatient Medical Facility ☐ Other, specify:			
#High Priority:	#Medium Priority:	#Low Priority:	Total # Contacts:
Please describe site environment(s) (i.e. large vs. small room, ventilation details, etc.)			
Investigation Activities			
Provide a timeline for all screening activities (completed and anticipated). Include specific dates where possible.			
Media Involvement			
Has the media become involved with this incident? ☐ Yes ☐ No ☐ Possible			
If yes, provide the name of media source and media contact person (if available) or all media involved:			