

TB Follow-Up Worksheet

Version 2.0 10/30/2007

A. Demographic Information

A1. Name (Last, First, Middle)		A2. Alien #:	A3. Visa Type:	A4. Initial U.S. Entry Date:
A5. Age:	A6. Gender:	A7. DOB:	A8. TB Class:	A9. Class Condition:
A10. Country of Examination:			A11. Country of Birth:	
A12. Data Entry Q-Station:		A13. Officer in Charge:		A14. Q-Station Phone:
A15c.			A16a. Sponsor Agency Name: A16b. Sponsor Agency Phone: A16c. Sponsor Agency Address:	

B. Jurisdictional Information

B1. Destination State:	B2. Jurisdiction:	B3. Jurisdiction Phone #:
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C. U.S. Evaluation

C1. Date of Initial U.S. Medical Evaluation: <u> / / </u>				
C2a. TST Placed:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
C2b. TST Placement Date:	<u> / / </u>			C2e. History of Previous Positive TST <input type="checkbox"/>
C2c. TST mm:	<u> </u>			
C2d. TST Interpretation:	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Unknown	
C3a. Quantiferon (QFT) Test:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
C3b. QFT Collection Date:	<u> / / </u>			
C3c. QFT Result:	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Unknown

U.S. Review of Overseas CXR	Domestic CXR	Comparison
C4. Overseas CXR Available? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Verifiable	C7. U.S. CXR Done? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Verifiable C8. Date of U.S. CXR: <u> / / </u>	C11. U.S. CXR Comparison to Overseas CXR: <input type="checkbox"/> Stable <input type="checkbox"/> Worsening <input type="checkbox"/> Improving <input type="checkbox"/> Unknown
C5. U.S. Interpretation of Overseas CXR: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Poor Quality <input type="checkbox"/> Unknown	C9. Interpretation of U.S. CXR: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown	
C6. Overseas CXR Abnormal Findings: <input type="checkbox"/> Abnormal, not TB <input type="checkbox"/> Cavity <input type="checkbox"/> Fibrosis <input type="checkbox"/> Infiltrate <input type="checkbox"/> Granuloma(ta) <input type="checkbox"/> Adenopathy <input type="checkbox"/> Other (Specify) _____	C10. U.S. CXR Abnormal Findings: <input type="checkbox"/> Abnormal, not TB <input type="checkbox"/> Cavity <input type="checkbox"/> Fibrosis <input type="checkbox"/> Infiltrate <input type="checkbox"/> Granuloma(ta) <input type="checkbox"/> Adenopathy <input type="checkbox"/> Other (Specify) _____	

C12. U.S. Microscopy / Bacteriology Specimen not collected in U.S.

Spec #	Specimen Source	Date	AFB Smear Result	Culture Result	Drug Resistance (DR)
1	_____	<u> / / </u>	<input type="checkbox"/> Not Done <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	<input type="checkbox"/> Not Done <input type="checkbox"/> NTM <input type="checkbox"/> Negative <input type="checkbox"/> Contaminated <input type="checkbox"/> MTB Complex <input type="checkbox"/> Unknown	<input type="checkbox"/> Not Done <input type="checkbox"/> Mono-RIF <input type="checkbox"/> No DR <input type="checkbox"/> MDR-TB <input type="checkbox"/> Mono-INH <input type="checkbox"/> Other DR
2	_____	<u> / / </u>	<input type="checkbox"/> Not Done <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	<input type="checkbox"/> Not Done <input type="checkbox"/> NTM <input type="checkbox"/> Negative <input type="checkbox"/> Contaminated <input type="checkbox"/> MTB Complex <input type="checkbox"/> Unknown	<input type="checkbox"/> Not Done <input type="checkbox"/> Mono-RIF <input type="checkbox"/> No DR <input type="checkbox"/> MDR-TB <input type="checkbox"/> Mono-INH <input type="checkbox"/> Other DR
3	_____	<u> / / </u>	<input type="checkbox"/> Not Done <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	<input type="checkbox"/> Not Done <input type="checkbox"/> NTM <input type="checkbox"/> Negative <input type="checkbox"/> Contaminated <input type="checkbox"/> MTB Complex <input type="checkbox"/> Unknown	<input type="checkbox"/> Not Done <input type="checkbox"/> Mono-RIF <input type="checkbox"/> No DR <input type="checkbox"/> MDR-TB <input type="checkbox"/> Mono-INH <input type="checkbox"/> Other DR

U.S. Review of Overseas Treatment

<p>C13. Overseas Treatment Recommended by Panel Physician:</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>	<p>C14. US Review of TB Disease Overseas Treatment:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If Yes</p> <p><input type="checkbox"/> Patient-Reported</p> <p><input type="checkbox"/> Panel Physician-Documented</p> <p><input type="checkbox"/> Both</p>	<p>C15. Arrived on Treatment:</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>	<p>C16. Completed Treatment Overseas:</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>
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C17. Overseas Treatment Concerns: Yes No

D. Disposition

D1. Disposition Date: / /

D2. Evaluation Disposition:

<p><input type="checkbox"/> Completed Evaluation</p> <p><input type="checkbox"/> Treatment Recommended</p> <p><input type="checkbox"/> No Treatment Recommended</p>	<p><input type="checkbox"/> Initiated Evaluation / Not Completed</p> <p><input type="checkbox"/> Moved within U.S.</p> <p><input type="checkbox"/> Lost to Follow-up</p> <p><input type="checkbox"/> Returned to Country of Origin</p> <p><input type="checkbox"/> Refused Evaluation</p> <p><input type="checkbox"/> Died</p> <p><input type="checkbox"/> Other, specify</p> <p>_____</p>	<p><input type="checkbox"/> Did Not Initiate Evaluation</p> <p><input type="checkbox"/> Not Located</p> <p><input type="checkbox"/> Moved within U.S.</p> <p><input type="checkbox"/> Lost to Follow-up</p> <p><input type="checkbox"/> Returned to Country of Origin</p> <p><input type="checkbox"/> Refused Evaluation</p> <p><input type="checkbox"/> Died</p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Other, specify</p> <p>_____</p>
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D3. Diagnosis: Class 0 - No TB exposure, not infected Class 1 - TB exposure, no evidence of infection

Class 2 - TB infection, no disease Class 3 - TB, active disease

Class 4 - TB, inactive disease Pulmonary Extrapulmonary Both Sites

D4. RVCT Reported D5. RVCT #: _____

E. U.S. Treatment

<p>E1. U.S. Treatment Initiated:</p> <p><input type="checkbox"/> No Treatment</p> <p><input type="checkbox"/> Active Disease</p> <p><input type="checkbox"/> LTBI</p> <p><input type="checkbox"/> Unknown</p>	<p>E2. U.S. Treatment Start Date:</p> <p> <u> / / </u></p>	<p>E3. U.S. Treatment Completed:</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>	<p>E4. U.S. Treatment End Date:</p> <p> <u> / / </u></p>
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F. Comments

	<p>Provider _____</p> <p>Clinic _____</p> <p>Phone _____</p>
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G. Physician Signature

Panel Physician Signature: _____ Date (mm-dd-yyyy) _____