

# Completing the Class B TB Follow-Up Worksheet

Helen Townsend MPH BSN RN  
TB Nurse Case Manager, MCPHD  
TB Regional Nurses Conference  
TB/Refugee Health Division, ISDH  
October 2015

# Objectives

- Participants will be able to
  - Explain the difference between DGMQ's "B1", "B2" and "B3" TB classifications
  - State the time frame for completion of the TB Follow-Up Worksheet
  - List the three activities that should be completed before a "B" is considered lost to follow-up

# What happens if the TB Follow-Up Worksheet is not returned on time?

- A. Nothing
- B. The “B” individual will not be able to get his/her visa validated
- C. Your Regional TB Nurse Consultant will call you to inquire about difficulties in getting the worksheet done
- D. The “B” individual will be in danger of being deported

## “B” refers to

- A. DGMQ (Division of Global Migration and Quarantine—part of CDC) classification of tuberculosis
- B. A CDC classification of foreign born individuals coming to the United States
- C. A type of visa

# Who is responsible for doing the **overseas** medical evaluation?

- A. Civil Surgeon
- B. A physician appointed by the U.S. embassy
- C. Any physician in the individuals country of origin
- D. Panel Physician

# Who is responsible for doing the domestic TB evaluation?

- A. Civil Surgeon
- B. Local Health Department
- C. Local Primary Care Provider
- D. B or C.

A “Class B1” is an applicant for entry into the USA who

- A. Has completed TB treatment overseas
- B. Has a physical exam or CXR findings suggestive of pulmonary TB
- C. Has negative sputum smears and cultures
- D. All the above

A “Class B2” is an applicant for entry into the USA who

- A. Has a TST  $\geq 10$  mm
- B. Has no signs or symptoms of TB
- C. Both A and B
- D. Needs to be evaluated for MDR TB

A “Class B3” is an applicant for entry into the USA who

- A. Is a contact to an active TB case
- B. May also be classified as B2
- C. May also be classified as B1
- D. All of the above

# Overseas Physicals

## **Required**

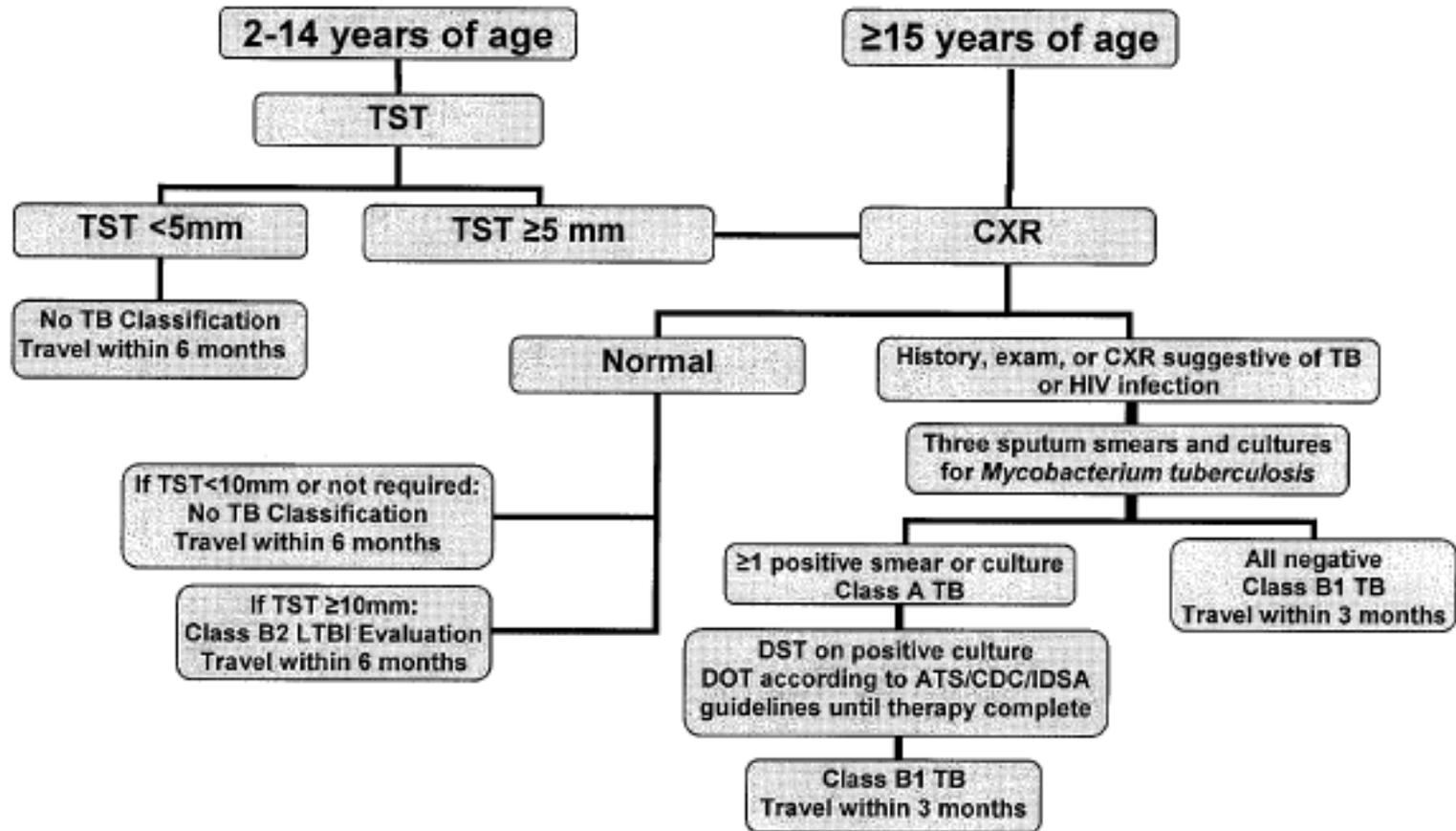
- Refugee
- Immigrants applying for permanent residency

## **Not Required**

- Tourist Visa
- Work Visa
- Student Visa

# 2007 Technical Instructions

**Figure 3.**  
**2007 New Technical Instructions for Tuberculosis Screening and Treatment, for Applicants in Countries with WHO-estimated Tuberculosis Incidence Rate of  $\geq 20$  Cases Per 100,000 Population**



# Class “A”

Class “A”: Applicants who have tuberculosis disease diagnosed (sputum smear + or culture +) and require treatment overseas but who have been granted a waiver to travel prior to the completion of therapy

# Class “B1”

Class “B1” Pulmonary– No treatment. Applicants who have medical history, physical exam, or CXR findings suggestive of pulmonary TB but have negative AFB sputum smears and cultures and are not diagnosed with TB or can wait to have TB treatment started after immigration

Class “B1” Pulmonary – Completed treatment. Applicants who were diagnosed with pulmonary TB and successfully completed DOT prior to immigration

Class “B1” Extra-pulmonary - Evidence of extra-pulmonary TB

# Class “B2”

Class “B2” – LTBI Evaluation. Applicants who have a TST  $\geq 10$  mm but who otherwise have a negative evaluation for TB

# Class “B3”

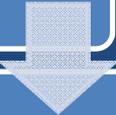
“Class B3” – Contact Evaluation. Applicants who are a contact of a known tuberculosis case

# What is EDN?

- Electronic Disease Notification System
- CDC database

# Sequence for TB Evaluations

Panel Physician DGMMQ



CDC -- EDN



ISDH – ITARA -- Fax



LHD – Evaluate -- Fax



ISDH – ITARA -- EDN

# Requirements for “B” follow-up

- All B1 and B2 arrivals need a new diagnostic evaluation for active disease
- Includes a TST (or IGRA) and
- New CXR and
- Sputum smears/cultures if symptomatic or CXR is indicative of TB
  
- Even if active TB disease is ruled out, most B1 and B2 arrivals are priority candidates for treatment of LTBI

# How long do you have?

- 30 days to initiate
- 90 days to complete

# Call → Send → Go

1. Call phone number on overseas paperwork
  - Will need to use interpreter if the individual does not speak English
2. Send a letter
  - May need to get it translated into the individual's language
  - Make it look official—Health Department letterhead
3. Make a home visit

All three steps **must** be completed before a Class B can be ruled out as “Lost to follow-up”

# 2016 Targeted Goals

45 % of all “Bs” should have their TB follow-up initiated within 30 days of arrival

72 % of all “Bs” should have their TB follow-up completed within 90 days of arrival

Allen and Marion Counties enter TB follow-up information into ITARA

All other counties fax TB follow-up worksheets to ISDH

# The Worksheet

- The TB Follow-up Worksheet is designed to
  - collect information on immigrants and refugees who have migrated to the US.
    - They were classified overseas during the required medical examination process with a TB condition.
    - Follow-up evaluation in the US was recommended.
- The TB Follow-up Worksheet is generated from the CDC's Electronic Disease Notification(EDN) system by ISDH.
- ISDH sends the overseas medical information and TB Follow-up Worksheet to the Local Health Department (the county of the immigrant's/refugee's residence).
- The Local Health Department submits the completed TB Follow-up Worksheet to ISDH.
- Information from the TB Follow-up Worksheet is entered into the EDN system by ISDH and then transferred electronically to CDC.

# Page 1

EDN TB Follow-Up Worksheet				Last reviewed: 6/21/2013
A. Demographic				
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. Country of examination:			A10. Country of birth:	
A11a. Address:		A12. a. Sponsor agency name:		
A11b. Phone:		b. Phone(s):		
A11c. Other:		c. Address:		
<b>B. Jurisdictional Information</b>				
B1. Arrival jurisdiction:			B2. Current jurisdiction:	
<b>C. U.S. Evaluation</b>				
C1. Date of initial U.S. medical evaluation: _____				
<b>Mantoux Tuberculin Skin Test (TST)</b>			<b>Interferon-Gamma Release Assay (IGRA)</b>	
C2a. Was a TST administered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			C3a. Was IGRA administered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If YES, C2b. TST placement date: _____ <input type="checkbox"/> Placement date unknown			If YES, C3b. Date collected: _____ <input type="checkbox"/> Date unknown	
C2c. TST mm: _____ <input type="checkbox"/> Unknown			C3c. IGRA brand: <input type="checkbox"/> QuantiFERON® <input type="checkbox"/> T-SPOT <input type="checkbox"/> Other (specify): _____	
C2d. TST interpretation: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown			C3d. Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Invalid <input type="checkbox"/> Unknown	
C2e. History of Previous Positive TST <input type="checkbox"/>			C3e. History of previous positive IGRA <input type="checkbox"/>	
<b>U.S. Review of Pre-Immigration CXR</b>		<b>U.S. Domestic CXR</b>		<b>Comparison</b>
C4. Pre-Immigration CXR available? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Verifiable		C7. U.S. domestic CXR done? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		C11. U.S. domestic CXR comparison to pre-immigration CXR: <input type="checkbox"/> Stable <input type="checkbox"/> Worsening <input type="checkbox"/> Improving <input type="checkbox"/> Unknown
C5. U.S. interpretation of pre-immigration CXR: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (must select one below): <input type="checkbox"/> Not consistent with active TB <input type="checkbox"/> Non-cavitary, consistent with TB <input type="checkbox"/> Cavitary, consistent with TB <input type="checkbox"/> Poor Quality <input type="checkbox"/> Unknown		If YES, C8. Date of U.S. CXR: _____ C9. Interpretation of U.S. CXR: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (must select one below): <input type="checkbox"/> Not consistent with active TB <input type="checkbox"/> Non-cavitary, consistent with TB <input type="checkbox"/> Cavitary, consistent with TB <input type="checkbox"/> Unknown		
C6. Other pre-immigration CXR abnormalities: <input type="checkbox"/> Volume loss <input type="checkbox"/> Infiltrate <input type="checkbox"/> Granuloma(ta) <input type="checkbox"/> Adenopathy <input type="checkbox"/> Other (specify) _____		C10. U.S. domestic CXR abnormalities: <input type="checkbox"/> Volume loss <input type="checkbox"/> Infiltrate <input type="checkbox"/> Granuloma(ta) <input type="checkbox"/> Adenopathy <input type="checkbox"/> Other (specify) _____		
<b>U.S. Review of Pre-Immigration Treatment</b>				
C12a. Completed treatment pre-immigration? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, <input type="checkbox"/> Treated for TB disease <input type="checkbox"/> Treated for LTBI			C13. Arrived on treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
C12b. Treatment start date: _____ <input type="checkbox"/> Start date unknown			If YES, <input type="checkbox"/> TB disease <input type="checkbox"/> LTBI	
C12c. Treatment end date: _____ <input type="checkbox"/> End date unknown			C13a. Start date: _____ <input type="checkbox"/> Start date unknown	
C12d. Treatment reported by: <input type="checkbox"/> Treatment documented on DS forms <input type="checkbox"/> Patient reported treatment completion <u>at</u> or <u>before</u> panel physician examination <input type="checkbox"/> Both documented on DS forms & patient reported <input type="checkbox"/> Unknown			C14. Pre-Immigration treatment concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES: <input type="checkbox"/> Treatment duration too short <input type="checkbox"/> Incorrect treatment regimen <input type="checkbox"/> Other, please specify: _____	
C12e. Standard TB treatment regimen was administered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to verify				

# Demographic & Jurisdictional Information

These sections are pre-populated by the EDN system.

If these sections are blank, enter Name, Alien # and DOB. That is sufficient.

A. Demographic		EDN TB Follow-Up Worksheet		Last reviewed: 6/21/2013	
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. Country of examination:			A10. Country of birth:		
A11a. Address: A11b. Phone: A11c. Other:			A12. a. Sponsor agency name: b. Phone(s): c. Address:		
B. Jurisdictional Information					
B1. Arrival jurisdiction:			B2. Current jurisdiction:		



# U.S. Review of Pre-immigration CXR

Only mark yes and complete this section if a clinician in the USA reviewed the film/disc brought by the immigrant/refugee from overseas. Please remind refugees/immigrants to take overseas film/disc with them when they get a new CXR in the USA so the radiologist can compare them. **Do not enter CXR information from the overseas paperwork.**

**NOTE:** If there is an abnormality other than what is listed in C6, check other and write the abnormality in the comments box at the bottom of page 2.

U.S Review of Pre-Immigration CXR	
C4. Pre-immigration CXR available?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Verifiable
C5. U.S. interpretation of pre-immigration CXR:	
<input type="checkbox"/> Normal	
<input type="checkbox"/> Abnormal (must select one below):	
	<input type="checkbox"/> Not consistent with active TB
	<input type="checkbox"/> Non-cavitary, consistent with TB
	<input type="checkbox"/> Cavitary, consistent with TB
<input type="checkbox"/> Poor Quality	
<input type="checkbox"/> Unknown	
C6. Other pre-immigration CXR abnormalities:	
<input type="checkbox"/> Volume loss	<input type="checkbox"/> Infiltrate <input type="checkbox"/> Granuloma(ta)
<input type="checkbox"/> Adenopathy	<input type="checkbox"/> Other (specify)

# U.S. Domestic CXR

It is recommended that all Bs get a CXR after immigration to the USA. This CXR should be compared to the film/disc they bring with them from overseas. Record information about the U.S. Domestic CXR here.

**NOTE:** If there is an abnormality other than what is listed in C10, check other and write the abnormality in the comments box at the bottom of page 2.

U.S. Domestic CXR	
C7. U.S. domestic CXR done?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If <b>YES</b> , C8. Date of U.S. CXR: ___/___/____	
C9. Interpretation of U.S. CXR:	
<input type="checkbox"/> Normal	
<input type="checkbox"/> Abnormal (must select one below):	
<input type="checkbox"/> Not consistent with active TB	
<input type="checkbox"/> Non-cavitary, consistent with TB	
<input type="checkbox"/> Cavitary, consistent with TB	
<input type="checkbox"/> Unknown	
C10. U.S. domestic CXR abnormalities:	
<input type="checkbox"/> Volume loss <input type="checkbox"/> Infiltrate <input type="checkbox"/> Granuloma(ta)	
<input type="checkbox"/> Adenopathy <input type="checkbox"/> Other (specify)	

# Comparison

If the radiologist in the USA compared the overseas film/disc with the U.S. Domestic CXR, record the comparison here.

Comparison	
C11. U.S. domestic CXR comparison to pre-immigration CXR:	
<input type="checkbox"/>	Stable
<input type="checkbox"/>	Worsening
<input type="checkbox"/>	Improving
<input type="checkbox"/>	Unknown

# Review of Overseas Treatment

If the physician who evaluated the immigrant/refugee overseas before immigration (panel physician) provided TB treatment, it will be documented in the overseas medical evaluation. However, if the immigrant/refugee was treated further in the past, there might not be any documentation of treatment. The physician in the USA who evaluates the immigrant /refugee needs to review any previous treatment with the patient. Do not simply copy information from the overseas paperwork into this section.

U.S. Review of Pre-Immigration Treatment	
<p>C12a. Completed treatment pre-immigration? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If YES,</i> <input type="checkbox"/> Treated for TB disease <input type="checkbox"/> Treated for LTBI</p> <p>C12b. Treatment start date: ___/___/___ <input type="checkbox"/> Start date unknown</p> <p>C12c. Treatment end date: ___/___/___ <input type="checkbox"/> End date unknown</p> <p>C12d. Treatment reported by:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Treatment documented on DS forms</li><li><input type="checkbox"/> Patient reported treatment completion <b>at</b> or <b>before</b> panel physician examination</li><li><input type="checkbox"/> Both-documented on DS forms &amp; patient reported</li><li><input type="checkbox"/> Unknown</li></ul> <p>C12e. Standard TB treatment regimen was administered?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to verify</p>	<p>C13. Arrived on treatment?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><i>If YES,</i> <input type="checkbox"/> TB disease <input type="checkbox"/> LTBI</p> <p>C13a. Start date: ___/___/___ <input type="checkbox"/> Start date unknown</p> <p>C14: Pre-Immigration treatment concerns?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If YES,</i></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Treatment duration too short</li><li><input type="checkbox"/> Incorrect treatment regimen</li><li><input type="checkbox"/> Other, please specify:</li></ul>

# Page 2

Allen #	EDN TB Follow-Up Worksheet (Cont)				Last reviewed: 6/21/2013				
C15. U.S. Microscopy/Bacteriology*		Sputa collected in U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No				*Covers all results regardless of sputa collection method			
#	Date Collected	AFB Smear		Sputum Culture		Drug Susceptibility Testing			
1	____/____/____	<input type="checkbox"/> Positive <input type="checkbox"/> Not Done	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown	<input type="checkbox"/> NTM <input type="checkbox"/> Contaminated <input type="checkbox"/> Not Done	<input type="checkbox"/> MTB Complex <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	<input type="checkbox"/> MDR-TB <input type="checkbox"/> Mono-INH <input type="checkbox"/> No DR	<input type="checkbox"/> Mono-RIF <input type="checkbox"/> Other DR <input type="checkbox"/> Not Done		
2	____/____/____	<input type="checkbox"/> Positive <input type="checkbox"/> Not Done	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown	<input type="checkbox"/> NTM <input type="checkbox"/> Contaminated <input type="checkbox"/> Not Done	<input type="checkbox"/> MTB Complex <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	<input type="checkbox"/> MDR-TB <input type="checkbox"/> Mono-INH <input type="checkbox"/> No DR	<input type="checkbox"/> Mono-RIF <input type="checkbox"/> Other DR <input type="checkbox"/> Not Done		
3	____/____/____	<input type="checkbox"/> Positive <input type="checkbox"/> Not Done	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown	<input type="checkbox"/> NTM <input type="checkbox"/> Contaminated <input type="checkbox"/> Not Done	<input type="checkbox"/> MTB Complex <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	<input type="checkbox"/> MDR-TB <input type="checkbox"/> Mono-INH <input type="checkbox"/> No DR	<input type="checkbox"/> Mono-RIF <input type="checkbox"/> Other DR <input type="checkbox"/> Not Done		
<b>D. Evaluation Disposition</b>									
D1. Evaluation disposition date: ____/____/____									
D2. Evaluation disposition:									
<input type="checkbox"/> Completed evaluation <i>If evaluation was completed, was treatment recommended?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB									
<input type="checkbox"/> Initiated Evaluation / Not completed <i>If evaluation was NOT completed, why not?</i> <input type="checkbox"/> Not Located <input type="checkbox"/> Moved within U.S., transferred to: <input type="checkbox"/> Lost to Follow-Up <input type="checkbox"/> Moved outside U.S. <input type="checkbox"/> Refused Evaluation <input type="checkbox"/> Died <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____									
<input type="checkbox"/> D3. Diagnosis <input type="checkbox"/> Class 0 - No TB exposure, not infected <input type="checkbox"/> Class 2 - TB infection, no disease <input type="checkbox"/> Class 4 - TB, inactive disease <input type="checkbox"/> Class 1 - TB exposure, no evidence of infection <input type="checkbox"/> Class 3 - TB, TB disease <input type="checkbox"/> Pulmonary <input type="checkbox"/> Extra-pulmonary <input type="checkbox"/> Both sites									
D <i>If diagnosed with TB disease,</i> <input type="checkbox"/> RVCT Reported      D5. RVCT #: _____ <input type="checkbox"/> RVCT # unknown									
<b>E. U.S. Treatment</b>									
E1. U.S. treatment initiated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									
<i>If NO, specify the reason:</i>									
<input type="checkbox"/> Patient declined against medical advice <input type="checkbox"/> Died <input type="checkbox"/> Unknown <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Moved outside the U.S. <input type="checkbox"/> Moved within U.S., transferred to: <input type="checkbox"/> Other (specify) _____									
<i>If YES:</i> <input type="checkbox"/> TB disease <input type="checkbox"/> LTBI									
E2. Treatment start date: ____/____/____									
E3. U.S. treatment completed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									
<i>If NO, specify the reason:</i>									
<input type="checkbox"/> Patient stopped against medical advice <input type="checkbox"/> Provider decision <input type="checkbox"/> Died <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Moved outside the U.S. <input type="checkbox"/> Unknown <input type="checkbox"/> Adverse effect <input type="checkbox"/> Moved within U.S., transferred to: <input type="checkbox"/> Other (specify) _____									
<i>If treatment was completed,</i> E4. Treatment completion date: ____/____/____									
<i>If treatment was initiated but NOT completed,</i> E5. Treatment end date: ____/____/____									
<b>F. Comments</b>									
<b>G. Screen Site Information</b>									
Provider's Name: _____									
Clinic Name: _____									
Telephone Number: _____									

# U.S. Microscopy/Bacteriology

Only mark No if no specimen of any kind was collected (sputum, bronchial wash, biopsy, gastric aspirate, etc)

If sputum, collect 3 samples, each at least 8 hours apart with one collected first thing in AM

Leave Drug Susceptibility Testing blank unless MTB Complex is checked under Culture Result

Record results of additional test(s) in **Comments**

Alien #		EDN TB Follow-Up Worksheet (Cont)				Last reviewed: 6/21/2013				
C15. U.S. Microscopy/Bacteriology*		Sputa collected in U.S.?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	*Covers all results regardless of sputa collection method.				
#	Date Collected	AFB Smear		Sputum Culture		Drug Susceptibility Testing				
1	___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> NTM	<input type="checkbox"/> MTB Complex	<input type="checkbox"/> MDR-TB	<input type="checkbox"/> Mono-RIF	<input type="checkbox"/> Mono-INH	<input type="checkbox"/> Other DR	<input type="checkbox"/> Not Done
		<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown	<input type="checkbox"/> Contaminated	<input type="checkbox"/> Negative	<input type="checkbox"/> No DR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown					
2	___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> NTM	<input type="checkbox"/> MTB Complex	<input type="checkbox"/> MDR-TB	<input type="checkbox"/> Mono-RIF	<input type="checkbox"/> Mono-INH	<input type="checkbox"/> Other DR	<input type="checkbox"/> Not Done
		<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown	<input type="checkbox"/> Contaminated	<input type="checkbox"/> Negative	<input type="checkbox"/> No DR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown					
3	___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> NTM	<input type="checkbox"/> MTB Complex	<input type="checkbox"/> MDR-TB	<input type="checkbox"/> Mono-RIF	<input type="checkbox"/> Mono-INH	<input type="checkbox"/> Other DR	<input type="checkbox"/> Not Done
		<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown	<input type="checkbox"/> Contaminated	<input type="checkbox"/> Negative	<input type="checkbox"/> No DR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown					



# U.S. Treatment

This section is for entry of information regarding tuberculosis treatment provided to immigrant/refugee in the USA

**E1** – Check Yes or No

If No, check the reason why and **submit** to ISDH now

If Yes, check LTBI or TB disease

**E2** – If E1 is Active Disease or LTBI, write MM/DD/YYYY that immigrant/refugee started treatment.

If treatment started **submit** to ISDH now

Write estimated date of completion in **Comments**

**E3** – If E3 is yes, write MM/DD/YYYY that immigrant/refugee finished treatment.

**Re-submit** to ISDH now

E. U.S. Treatment	
E1. U.S. treatment initiated:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<i>If NO, specify the reason:</i>	
<input type="checkbox"/> Patient declined against medical advice	<input type="checkbox"/> Lost to follow-up
<input type="checkbox"/> Died	<input type="checkbox"/> Moved outside the U.S.
<input type="checkbox"/> Unknown	<input type="checkbox"/> Moved within U.S, transferred to:
<input type="checkbox"/> Other (specify)	
<i>If YES:</i>	<input type="checkbox"/> TB disease <input type="checkbox"/> LTBI
E2. Treatment start date:	___/___/___
E3. U.S. treatment completed:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<i>If NO, specify the reason:</i>	
<input type="checkbox"/> Patient stopped against medical advice	<input type="checkbox"/> Lost to follow-up
<input type="checkbox"/> Provider decision	<input type="checkbox"/> Moved outside the U.S.
<input type="checkbox"/> Died	<input type="checkbox"/> Moved within U.S, transferred to:
<input type="checkbox"/> Unknown	<input type="checkbox"/> Other (specify)
<i>If treatment was completed,</i>	E4. Treatment completion date: ___/___/___
<i>If treatment was initiated but NOT completed,</i>	E5. Treatment end date: ___/___/___

# Comments

F - Enter comments as desired.

F. Comments

# Screen Site Information

**G** – The worksheet data are sent to CDC electronically; therefore, the physician's signature is not required. Please write the Physician's name and clinic information on the worksheet.

## G. Screen Site Information

Provider's Name:

Clinic Name:

Telephone Number:

# Questions???