

CASE REPORT FORM**Tuberculosis**

Tuberculosis		EpiSurv No. _____	
Disease Name			
<input type="radio"/> Tuberculosis disease - new case		<input type="radio"/> Tuberculosis disease - relapse or reactivation	
<input type="radio"/> Latent tuberculosis infection (patient consent required)		<input type="radio"/> Tuberculosis infection - old disease on preventive treatment (fully investigated and active disease excluded)	
Reporting Authority			
Name of Public Health Officer responsible for case _____			
Notifier Identification			
Reporting source*			
<input type="radio"/> General Practitioner		<input type="radio"/> Hospital-based Practitioner	
<input type="radio"/> Self-notification		<input type="radio"/> Outbreak Investigation	
		<input type="radio"/> Laboratory	
		<input type="radio"/> Other	
Name of reporting source _____		Organisation _____	
Date reported* _____		Contact phone _____	
Usual GP _____		Practice _____	
		GP phone _____	
GP/Practice address			
Number _____		Street _____	
		Suburb _____	
Town/City _____		Post Code _____	
		<input type="checkbox"/> GeoCode _____	
Case Identification			
Name of case*		Surname _____ Given Name(s) _____	
NHI number* _____		Email _____	
Current address*			
Number _____		Street _____	
		Suburb _____	
Town/City _____		Post Code _____	
		<input type="checkbox"/> GeoCode _____	
Phone (home) _____		Phone (work) _____	
		Phone (other) _____	
Case Demography			
Location TA* _____		DHB* _____	
Date of birth* _____		OR Age _____	
		<input type="radio"/> Days	
		<input type="radio"/> Months	
		<input type="radio"/> Years	
Sex*			
<input type="radio"/> Male		<input type="radio"/> Female	
		<input type="radio"/> Indeterminate	
		<input type="radio"/> Unknown	
Occupation* _____			
Occupation location			
<input type="radio"/> Place of Work			
<input type="radio"/> School			
<input type="radio"/> Pre-school			
Name _____			
Address			
Number _____		Street _____	
		Suburb _____	
Town/City _____		Post Code _____	
		<input type="checkbox"/> GeoCode _____	
Alternative location			
<input type="radio"/> Place of Work			
<input type="radio"/> School			
<input type="radio"/> Pre-school			
Name _____			
Address			
Number _____		Street _____	
		Suburb _____	
Town/City _____		Post Code _____	
		<input type="checkbox"/> GeoCode _____	
Ethnic group case belongs to* (tick all that apply)			
<input type="checkbox"/> NZ European		<input type="checkbox"/> Maori	
		<input type="checkbox"/> Samoan	
		<input type="checkbox"/> Cook Island Maori	
<input type="checkbox"/> Niuean		<input type="checkbox"/> Chinese	
		<input type="checkbox"/> Indian	
		<input type="checkbox"/> Tongan	
<input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan)		*(specify) _____	

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Basis of Diagnosis		
LABORATORY CRITERIA		
Meets laboratory criteria for disease*	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Unknown
Demonstration of acid-fast bacilli in a clinical specimen	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Done <input type="radio"/> Awaiting Results
If yes, specify site	<input type="radio"/> Sputum	<input type="radio"/> Other (specify) _____
Isolation of Mycobacterium tuberculosis, or M. bovis from a clinical specimen	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Done <input type="radio"/> Awaiting Results
If yes, specify site	<input type="radio"/> Sputum	<input type="radio"/> Other (specify) _____
Demonstration of M. tuberculosis nucleic acid (PCR or LCR only)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Done <input type="radio"/> Awaiting Results
If yes, specify site	<input type="radio"/> Sputum	<input type="radio"/> Other (specify) _____
Histology strongly suggestive of tuberculosis	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Done <input type="radio"/> Awaiting Results
MANTOUX STATUS		
Mantoux tests done*	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Awaiting Results <input type="radio"/> Unknown
Date* _____	mm induration* _____	Date* _____ mm induration* _____
Mantoux status* (tick most appropriate - must use definitions in TB guidelines)		
<input type="radio"/> Mantoux Negative	<input type="radio"/> Mantoux Positive	<input type="radio"/> Mantoux Converted <input type="radio"/> Mantoux Unknown
IGRA STATUS		
Test done*	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Awaiting Results <input type="radio"/> Unknown
If yes, result	<input type="radio"/> Positive <input type="radio"/> Negative	<input type="radio"/> Indeterminate
OTHER CRITERIA		
Treatment for presumptive TB*	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Unknown
Interim treatment for presumptive LTBI in children < 5 years*	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Unknown
STATUS*		
<input type="radio"/> Under investigation	<input type="radio"/> Probable - presumptive	<input type="radio"/> Confirmed <input type="radio"/> Not a case
(no laboratory confirmation) (laboratory confirmation)		
PREVIOUS HISTORY OF TUBERCULOSIS (relapses or reactivations only)		
Date of first tuberculosis diagnosis* _____	Name of doctor* _____	
Place where diagnosis made (town/city/country)* _____		
Was diagnosis confirmed by laboratory testing?*	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Unknown
Was the case treated?*	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Unknown
If yes, duration of treatment* _____	months	
ADDITIONAL CLINICAL DETAILS		
Site of disease (disease only)		
Pulmonary*	<input type="radio"/> Yes <input type="radio"/> No	
If yes,		
Radiology*	<input type="radio"/> Normal <input type="radio"/> Active TB	<input type="radio"/> TB of Uncertain Activity <input type="radio"/> Not Done <input type="radio"/> Unknown
Evidence of cavity formation*	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Unknown

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Basis of Diagnosis (continued)		
Extrapulmonary* <input type="radio"/> Yes <input type="radio"/> No		
If yes, tick all that apply*		
<input type="checkbox"/> Lymph node (excl abdomen)	<input type="checkbox"/> Pleural	<input type="checkbox"/> MiliaryTB
<input type="checkbox"/> Bone/joint	<input type="checkbox"/> Intraabdominal (excl renal)	<input type="checkbox"/> Renal/genitourinary tract
<input type="checkbox"/> Soft tissue/skin	<input type="checkbox"/> CNS TB (including meningitis)	
<input type="checkbox"/> Other site, specify _____		
How was case/infection discovered?*		
<input type="radio"/> Contact follow-up	<input type="radio"/> Immigrant/refugee screening	<input type="radio"/> Attended practitioner with symptoms
<input type="radio"/> Other (specify) _____		<input type="radio"/> Unknown
ADDITIONAL LABORATORY DETAILS (CULTURE POSITIVE CASES ONLY and ESR UPDATED)		
Mycobacterial species <input type="radio"/> <i>Mycobacterium tuberculosis</i> <input type="radio"/> <i>M. bovis</i>		
<input type="radio"/> Other (*specify) _____		
Susceptibility testing results		
Isoniazid (0.1 mg/L)	<input type="radio"/> Susceptible	<input type="radio"/> Resistant
Isoniazid (0.4 mg/L)	<input type="radio"/> Susceptible	<input type="radio"/> Resistant
Rifampicin	<input type="radio"/> Susceptible	<input type="radio"/> Resistant
Ethambutol	<input type="radio"/> Susceptible	<input type="radio"/> Resistant
Pyrazinamide	<input type="radio"/> Susceptible	<input type="radio"/> Resistant
Streptomycin	<input type="radio"/> Susceptible	<input type="radio"/> Resistant
<i>Other antibiotics (specify)</i>		
_____	<input type="radio"/> Susceptible	<input type="radio"/> Resistant
_____	<input type="radio"/> Susceptible	<input type="radio"/> Resistant
_____	<input type="radio"/> Susceptible	<input type="radio"/> Resistant
_____	<input type="radio"/> Susceptible	<input type="radio"/> Resistant
_____	<input type="radio"/> Susceptible	<input type="radio"/> Resistant
_____	<input type="radio"/> Susceptible	<input type="radio"/> Resistant
_____	<input type="radio"/> Susceptible	<input type="radio"/> Resistant
Specimen details		
Date specimen taken _____	Specimen number _____	
Updated <input type="checkbox"/>	Reference laboratory _____	Date results updated _____
Molecular Typing		
MIRU _____	RFLP _____	ClusterID _____
Updated <input type="checkbox"/>	Date Results Updated _____	Specimen Number _____
Clinical Course and Outcome		
Date of onset* _____		
<input type="checkbox"/> Approximate		<input type="checkbox"/> Unknown
<input type="checkbox"/> Asymptomatic		
Hospitalised* <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
Date hospitalised* _____		
<input type="checkbox"/> Unknown		
Hospital* _____		

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Clinical Course and Outcome continued			
Died*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
Date died*	_____	<input type="checkbox"/> Unknown	
Was this disease the primary cause of death?*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
If no, specify the primary cause of death*		_____	
Outbreak Details			
Is this case part of an outbreak (i.e. known to be linked to one or more other cases of the same disease)?*			
<input type="checkbox"/> Yes		If yes, specify Outbreak No* _____	
Risk Factors			
Has HIV test been performed*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
Other immunosuppressive illness (chronic renal failure, alcoholism, diabetes, gastrectomy)*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
If yes, specify _____			
Immunosuppressive medication*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
Contact with a confirmed case of tuberculosis*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
If yes, specify nature of contact* _____			
If yes, did contact occur within New Zealand*		<input type="radio"/> Yes	<input type="radio"/> No
If yes, specify name of case* _____			
Born outside New Zealand*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
If yes, specify country of birth* _____			
If yes, date of arrival in NZ* _____		<input type="checkbox"/> Unknown	
Current or recent residence in a household with a person(s) born outside New Zealand*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
If yes, specify country of birth* _____			
Exposure in health care setting*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
If yes, specify exposure* _____			
Current or recent residence in an institution (e.g. prison)*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
If yes, specify details* _____			
Exposure to cattle, deer, possums, other wild animals or animal products in work or recreation (<i>M. bovis</i> infection only)*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
* If yes, specify exposure in detail _____			
Other risk factors for tuberculosis*			
(specify*) _____			

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Protective Factors	
At any time prior to onset, had the case been immunised with BCG vaccine?* <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, specify date given* _____ <input type="checkbox"/> Unknown If yes, how was this confirmed* <input type="radio"/> Scar <input type="radio"/> Patient/Caregiver recall <input type="radio"/> Documented <input type="radio"/> Unknown	
Management	
CASE MANAGEMENT	
Under specialist care* <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown Name of specialist* _____	
Did the case receive treatment?* <input type="radio"/> Yes <input type="radio"/> Treatment declined <input type="radio"/> Treatment inappropriate <input type="radio"/> Unknown If yes Date treatment started* _____ <input type="checkbox"/> Unknown Date treatment ended in NZ* _____ <input type="checkbox"/> Unknown Was treatment interrupted?* <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown Reason treatment ended* <input type="radio"/> Tmt completed to the satisfaction of the prescribing doctor <input type="radio"/> Transferred to overseas medical care <input type="radio"/> Went overseas (medical care not transferred or unknown) <input type="radio"/> Died <input type="radio"/> Refused to complete treatment <input type="radio"/> Stopped treatment because of adverse effects <input type="radio"/> Stopped due to pregnancy <input type="radio"/> Lost to follow up <input type="radio"/> Discontinuation of interim treatment for LTBI (child <5 years) <input type="radio"/> Reason unknown Did case receive DOT throughout the intensive phase of treatment?* <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown Did case receive DOT throughout the course of treatment?* <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
CONTACT MANAGEMENT (disease only)	
Did case have any contacts at risk of infection?* <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <i>If yes, type of contact:</i> <i>Number Identified</i> Close contacts* _____ Casual contacts* _____	
Comments*	