# Tuberculosis Follow-Up Worksheet Reference Guide

Electronic Disease Notification System (EDN)

Washington State Department of Health

DOH 420-295 November 2021

# Contents

# 1 About this Guide

This document is intended as a guideline for local health jurisdictions in completion of the revised Electronic Disease Notification (EDN) Tuberculosis Follow-Up Worksheet (2019); the document outlines directions for completing these forms and alerts users to common errors which may lead to delays or poor data quality. Questions not covered in this guidance document may be directed to the Washington State TB Program for assistance and clarification.

For people with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY call 711).

# 2 Contact

Washington State Department of Health TB Program
Email: tbservices@doh.wa.gov
Phone: 206-418-5500
Fax: 206-364-1060

# 3 General guidance

## 3.1 Dates

It is important to capture any date information available, even if an entire date is not known. If a question asks for a date, please indicate any information that is known, even if incomplete. For example, if a test was performed sometime in 2010 but the day or month is not known, please write in "2010" and leave the day and month blank.

## 3.2 Supplemental information

If supplemental information is available for any question on this worksheet that is relevant to the evaluation, please indicate this information in section H: Comments. Supplemental information indicated elsewhere on the form will likely be captured upon data entry into the EDN interface, but cannot be guaranteed.

## 3.3 Transferring Jurisdictions

If you learn that an arriver has relocated to a different jurisdiction, **please alert Department of Health (DOH) staff by secure email at tbservices@doh.wa.gov**, or by fax/phone, providing new forwarding contact information for the arriver (address and telephone number). Interjurisdictional transfers should be initiated as quickly as possible (within a work week), because the arriver may need to initiate or complete their follow-up evaluation and may need additional care.

If you learn of an arriver having transferred to your jurisdiction and you are unable to see their record in EDN, contact DOH staff to have the record transferred to your jurisdiction.

# 4 Section A: Demographics

| A. Demographic | | | |
|---|---|---|---|
| **A1. Name (Last, First, Middle):** | **A2. Alien #:** | **A3. Visa type:** | **A4. Initial U.S. entry date:** |
| A5. Age: / A6. Sex: | A7. DOB: ___/___/_____ | A8. TB Class Based on *Technical Instructions for Panel Physicians*: | |
| A9. Country of examination: | | A10. Country of birth: | |
| A11a. Name in care of:<br>A11b. Phone number:<br>A11c. Address: | | A12a. Sponsor agency name:<br>A12b. Phone number:<br>A12c. Address: | |

The EDN system will automatically populate these fields. If you have information to suggest listed name, sex, date of birth (DOB), or age is incorrect, please note the changes on the form and DOH staff will have this information verified/corrected in the EDN system.

# 5 Section C: U.S. Evaluation

Please note: It is recommended that the U.S. evaluation be initiated within **30 days** of the immigrant or refugee's arrival date.

## 5.1 C1 – U.S. Evaluation

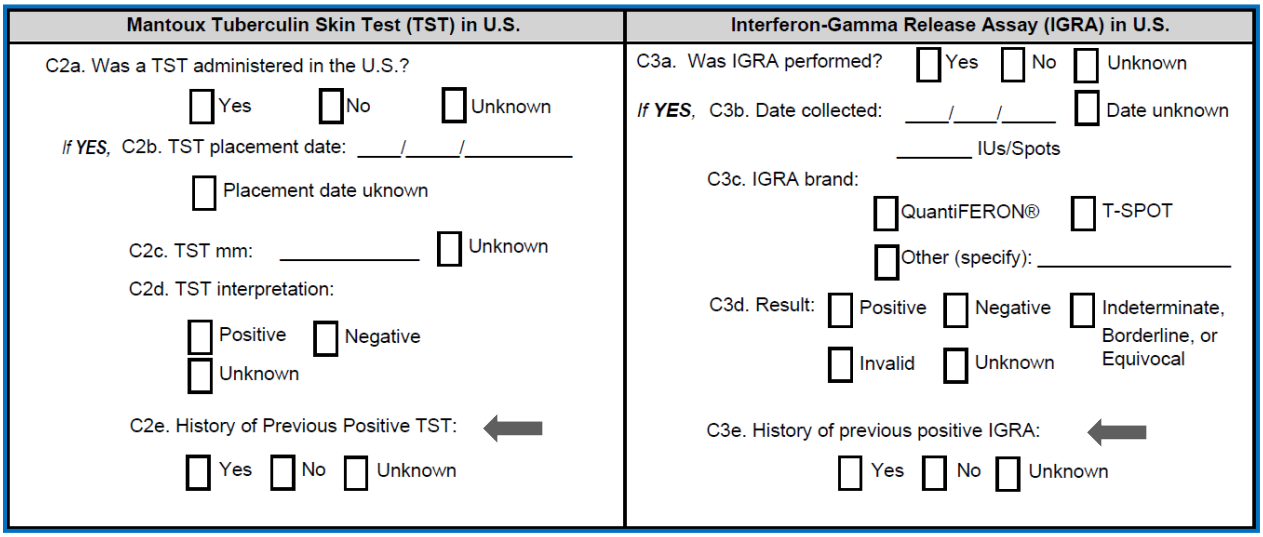
| C. U.S. Evaluation |
|---|
| C1. Date of first U.S. test or provider/clinic visit: _____/_____/_____ |

Please note that this date is the date the arriver was first seen in a healthcare setting after arrival. **This is not the date when the health department first contacted the arriver.**

This date is required in EDN if any other items in section C are filled out; please take care to fill out this field if the evaluation will be marked as 'Completed Evaluation' or 'Initiated Evaluation/Not Completed.'

If the U.S.-based provider determines physical interaction is not required, then the date when determination was made should be used.

## 5.2 C2, C3 – TST/IGRA (in U.S.)



| Mantoux Tuberculin Skin Test (TST) in U.S. | Interferon-Gamma Release Assay (IGRA) in U.S. |
|---|---|
| C2a. Was a TST administered in the U.S.? ☐ Yes ☐ No ☐ Unknown<br>*If **YES**,* C2b. TST placement date: ____/____/_____<br>☐ Placement date uknown<br>C2c. TST mm: _____ ☐ Unknown<br>C2d. TST interpretation:<br>☐ Positive ☐ Negative ☐ Unknown<br>C2e. History of Previous Positive TST: ☐ Yes ☐ No ☐ Unknown | C3a. Was IGRA performed? ☐ Yes ☐ No ☐ Unknown<br>*If **YES**,* C3b. Date collected: ____/____/_____ ☐ Date unknown<br>_____ IUs/Spots<br>C3c. IGRA brand:<br>☐ QuantiFERON® ☐ T-SPOT<br>☐ Other (specify): _____<br>C3d. Result: ☐ Positive ☐ Negative ☐ Indeterminate, Borderline, or Equivocal ☐ Invalid ☐ Unknown<br>C3e. History of previous positive IGRA: ☐ Yes ☐ No ☐ Unknown |

Please note that C2a and C3a are asking about tests administered **post-U.S. arrival**. If an arriver has a history of a previous positive test, this can be indicated in C2e and/or C3e (see arrows above).

### MANTOUX TUBERCULIN SKIN TEST (TST)

C2a: Indicate if a TST was administered during the domestic screening for tuberculosis (TB) (post-U.S. arrival).

C2b: if exact date of TST placement is unknown, enter any date information that is known; otherwise check 'Placement date unknown.' Note that this field is for the date the TST was **placed**, not the date it was read.

C2c: Indicate the millimeters of induration for the TST, if available.

C2d: Indicate interpretation of TST reaction, per ATS/IDS/CDC Guidelines.

C2e: If the arriver had a previous positive TST, indicate this under C2e, 'History of Previous Positive TST.' **Indicate a previous positive history only if it is documented on a medical record or DS form (patient verbal confirmation alone is not sufficient).** If you would like to document patient verbal report of previous positive history, please indicate this information in section H: Comments

### INTERFERON-GAMMA RELEASE ASSAY (IGRA)

C3a: Indicate if an IGRA was performed during the domestic screening for TB (post-U.S. arrival).

C3b: If exact date of specimen collection for IGRA test is unknown, enter any date information that is known; otherwise check 'Date unknown.' Indicate quantitative test results (IUs/Spots) if applicable. For the QFT TB-Plus test, please list the nil, TB1, TB2, and mitogen values in section H: Comments.

C3c: Indicate the specific brand of IGRA. If the specific brand is not listed, select 'Other, specify' and indicate the brand.

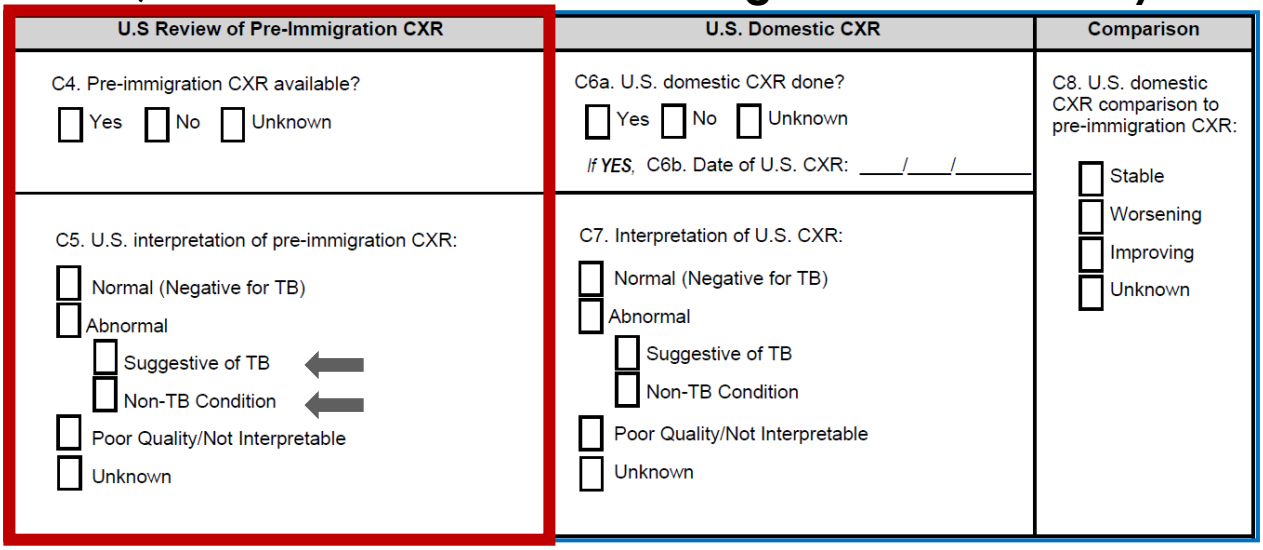
C3d: Indicate the IGRA test result.

- 'Positive' – means that it is probable that the person is infected with *M. tuberculosis*.
- 'Negative' – means that it is unlikely that the person is infected with *M. tuberculosis*.
- 'Indeterminate, Borderline, or Equivocal' – means that the results are in between final determinations and one answer cannot be selected with full confidence.
- 'Invalid' – means that the results are inconclusive or cannot be interpreted.
- 'Unknown' – means that it is not known whether the QFT was performed, or if the results are not known.

**If more than one IGRA result is available**, indicate information for whichever result guided clinical judgement the most. If you would like to document multiple IGRA test results, please indicate this information in section H: Comments.

**If the arriver had a previous positive IGRA**, indicate this under C3e, 'History of previous positive IGRA.' **Indicate a previous positive history only if it is documented on a medical record or DS form (patient verbal confirmation alone is not sufficient).** If you would like to document patient verbal report of previous positive history, please indicate this information in section H: Comments

## 5.3 C4, C5 – U.S. Review of Pre-Immigration Chest X-Ray




Please note that C4 and C5 refer to the **U.S. review** of the overseas chest x-ray (CXR), not a transcription of the overseas medical evaluation.

C4: This question refers to whether the overseas chest x-ray was **available to the U.S. clinician for review**, and has both the arriver's name and date of birth as identifiers.

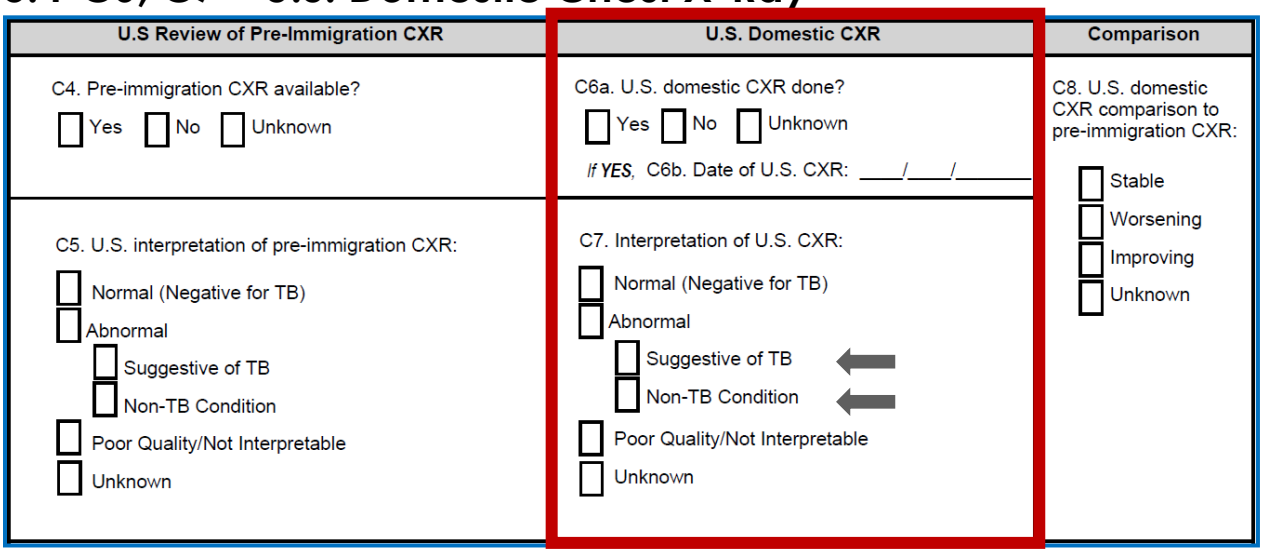
If the overseas chest x-ray is physically available but does not have both the arriver's name and date of birth as identifiers, select "Unknown" for this question.

C5: Indicate the **U.S. clinician's** interpretation of the overseas chest x-ray. If no chest x-ray is physically available, indicate "Unknown" for this question. **Please do not transcribe what was reported on the overseas medical evaluation to complete this section.**

**If the U.S. clinician indicates an "Abnormal" interpretation, please select ONE appropriate corresponding sub-selection (see arrows above). This is a requirement for data entry into EDN in this circumstance.**

If specific details are indicated about abnormalities, please enter this information in Section H: Comments

## 5.4 C6, C7 – U.S. Domestic Chest X-Ray




Please note that C6 and C7 refer to a chest x-ray done during domestic screening **in the U.S.**

C6a: Indicate if a chest x-ray was done during domestic screening for TB. If it is not known whether a chest x-ray was done for the arriver or the interpretation of the domestic chest x-ray is not known for reasons other than pending results, please indicate 'Unknown.'

C6b: If no chest x-ray was taken in the U.S., leave blank. If the exact date of U.S. domestic chest x-ray is unknown, enter any date information that is known (for example, if month and year are known and day is not, enter month and year). If C6a is marked 'Yes,' date information for C6b is required for entry into the EDN system.

C7: Indicate the interpretation of the U.S. domestic chest x-ray. **If an 'Abnormal' interpretation is indicated, please select ONE appropriate corresponding sub-selection (see arrows above). This is a requirement for data entry into EDN in this circumstance.** If a U.S. domestic chest x-ray was done but interpretation is not known, select 'Unknown' for this question.

## 5.5 C8 – Chest X-Ray Comparison

| U.S Review of Pre-Immigration CXR | U.S. Domestic CXR | Comparison |
|---|---|---|
| C4. Pre-immigration CXR available?<br>☐ Yes ☐ No ☐ Unknown | C6a. U.S. domestic CXR done?<br>☐ Yes ☐ No ☐ Unknown<br>*If **YES**,* C6b. Date of U.S. CXR: ____/____/_____ | C8. U.S. domestic CXR comparison to pre-immigration CXR:<br>☐ Stable<br>☐ Worsening<br>☐ Improving<br>☐ Unknown |
| C5. U.S. interpretation of pre-immigration CXR:<br>☐ Normal (Negative for TB)<br>☐ Abnormal<br>☐ Suggestive of TB<br>☐ Non-TB Condition<br>☐ Poor Quality/Not Interpretable<br>☐ Unknown | C7. Interpretation of U.S. CXR:<br>☐ Normal (Negative for TB)<br>☐ Abnormal<br>☐ Suggestive of TB<br>☐ Non-TB Condition<br>☐ Poor Quality/Not Interpretable<br>☐ Unknown | |

Indicate whether the U.S. clinician determined the U.S. chest x-ray to be stable, worsening, or improving when compared to the pre-immigration chest x-ray. **The section should be completed only if a U.S domestic CXR has been completed and an overseas CXR is physically available and verifiable (the name and date of birth are on the CXR). Please select "unknown" if an overseas or U.S. domestic CXR are not available/missing or if a final result for comparison is inconclusive.**

## 5.6 C9, C10, C11 – U.S. Review of Pre-Immigration Treatment

**U.S. Review of Pre-Immigration Treatment**

C9a. Completed treatment pre-immigration? ☐ Yes ☐ No ☐ Unknown

*If **YES**,* C9b. ☐ Treated for TB disease ☐ Treated for LTBI ☐ Treated, but unknown if TB disease or LTBI

*If Treated for TB disease,*

☐ Treatment completed **prior** to panel physician examination

☐ Treatment completed **after** panel physician diagnosis (DS 3030)

☐ At designated DOT site

☐ At non-designated DOT site

☐ Other, specify:_____

C9c. Treatment start date: ___/___/____ ☐ Start date unknown

C9d. Treatment end date: ___/___/____ ☐ End date unknown

C9e. Report of treatment administered prior to panel physician examination:

☐ Treatment documented on overseas medical history form (DS 3026)

☐ Documented on DS forms & patient reported at panel physician examination

☐ After U.S. arrival only, patient verbally reported treatment completion

☐ Unknown

C9f. Standard TB treatment regimen was administered?

☐ Yes ☐ No ☐ Unable to verify

C10a. Arrived to the U.S. on treatment?

☐ Yes ☐ No ☐ Unknown

*If **YES**,* C10b. ☐ Treated for TB disease ☐ Treated for LTBI

C10c. Start date: ___/___/____ ☐ Start date unknown

C11a: Pre-Immigration treatment concerns?

☐ Yes ☐ No

*If **YES**,* C11b. *Select all that apply:*

☐ Treatment duration too short

☐ Incorrect treatment regimen

☐ Inadequate information provided

☐ Lack of adequate diagnostics

☐ Unknown DOT/adherence status

☐ Other, please specify: _____

C9a: If treatment for latent tuberculosis infection (LTBI) or active TB disease was completed pre-immigration, please indicate 'Yes' and whether the arriver was treated for LTBI or active TB disease (C9b).

**Fill out data items C9b – C9f only if you have selected "Yes" for C9a.**

If C9a is marked 'Yes,' and C9b is marked 'Treated for TB disease,' please indicate whether that treatment was completed prior to or following the arriver's overseas panel physician examination. If treatment was completed after panel physician diagnosis, indicate where treatment took place (see arrows above).

C9c, C9d: If exact dates of treatment are unknown, enter any date information that is known/available (for example, if month and year are known and day is not, enter month and year).

C9e: If overseas treatment for LTBI or TB disease was administered, indicate how and when the treatment was reported. Select only one answer for this question. If this information is unavailable, select 'Unknown.'

C9f: Indicate whether a standard TB treatment regimen was administered. If this information is unavailable, select 'Unable to verify.'

C10a: Indicate if the immigrant or refugee arrived to the U.S. on treatment.

C10b, C10c: If the immigrant or refugee arrived on treatment, indicate whether they arrived on treatment for TB disease or LTBI, and the start date of their treatment, if available.

C11a: Indicate whether the U.S. clinician has concerns regarding pre-immigration treatment. If there are concerns, the U.S. clinician should indicate this by selecting all that apply for C11b and/or providing more detailed comments in section H.

## 5.7 C12 – U.S. Microscopy/Bacteriology

**C12. U.S. Microscopy/Bacteriology*** Sputa collected in U.S.? ☐ Yes ☐ No **Covers all results regardless of sputa collection method.*

| # | Date Collected | AFB Smear | Sputum Culture | Drug Susceptibility Testing |
|---|---|---|---|---|
| 1 | ___/___/_____ | ☐ Positive ☐ Negative ☐ Not Done ☐ Unknown | ☐ NTM ☐ MTB Complex ☐ Contaminated ☐ Negative ☐ Not Done ☐ Unknown | ☐ MDR-TB ☐ Mono-RIF ☐ Mono-INH ☐ Other DR ☐ No DR ☐ Not Done |
| 2 | ___/___/_____ | ☐ Positive ☐ Negative ☐ Not Done ☐ Unknown | ☐ NTM ☐ MTB Complex ☐ Contaminated ☐ Negative ☐ Not Done ☐ Unknown | ☐ MDR-TB ☐ Mono-RIF ☐ Mono-INH ☐ Other DR ☐ No DR ☐ Not Done |
| 3 | ___/___/_____ | ☐ Positive ☐ Negative ☐ Not Done ☐ Unknown | ☐ NTM ☐ MTB Complex ☐ Contaminated ☐ Negative ☐ Not Done ☐ Unknown | ☐ MDR-TB ☐ Mono-RIF ☐ Mono-INH ☐ Other DR ☐ No DR ☐ Not Done |

C12: Indicate whether sputa were collected **in the U.S.**

*Note:* 'Sputum' includes spontaneous and induced sputum. Sputum or pulmonary secretions obtained by bronchoscopy procedures or gastric aspiration should also be included. **Do NOT include tracheal suction**. Examples of specimen sources include sputum and bronchial washing. Please note that these specimen guidelines apply only to this form, and should not be used for other TB surveillance or reporting documents.

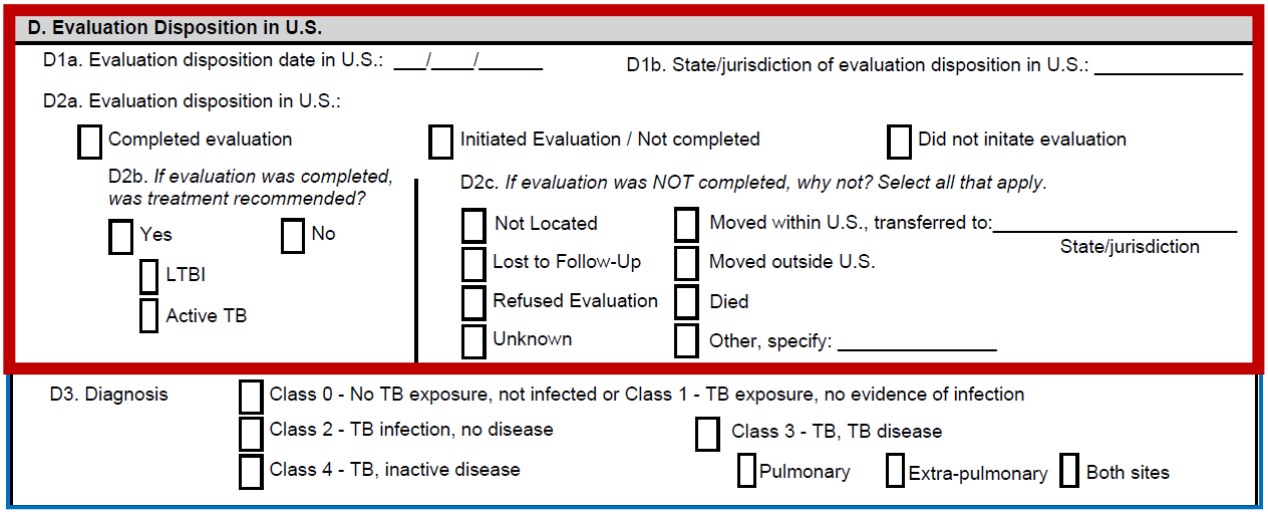
If sputa were collected, at least one sputum collection date is required for data entry into EDN. If exact dates of specimen collection are unknown, enter any date information that is known/available (for example, if month and year are known and day is not, enter month and year).

Indicate all test results that are known. If any result is unknown, select 'Unknown.' If a result says "unsatisfactory", select 'Unknown.'

**Helpful definitions:**

Not Done: Test not performed
NTM: Non-tuberculosis mycobacteria. This includes *M. avium* complex.
Contaminated: Sputum culture test for AFB is known to have been contaminated.
MTB Complex: Culture results are positive for growth of *Mycobacterium tuberculosis* complex (*M. tuberculosis, M. bovis, M. africanum*).
Mono-Rif: Any specimen cultures resistant only to Rifampin. Specimen cultures resistant to Rifampin and another drug (except Isoniazid) would be noted under Other Drug Resistance ('Other DR').
No DR: Pansusceptible
MDR-TB: Multiple drug-resistant tuberculosis
Mono-INH: Any specimen cultures resistant only to Isoniazid (regardless of concentration level of resistance). Specimen cultures resistant to Isoniazid and another drug (except Rifampin) would be noted under Other Drug Resistance ('Other DR').
Other DR: Resistance to drugs or a drug combination not listed above. Please record the resistance pattern in section H: Comments.

# 6 Section D: Evaluation Disposition in U.S.




## 6.1 D1 – Evaluation Disposition Date/Jurisdiction in U.S.

D1a: Evaluation disposition date in the U.S. indicates when a medical diagnosis for the patient has been made or reason that a medical diagnosis cannot be determined upon completion, initiation, or no initiation of evaluation of the patient. Please also indicate the state/jurisdiction of evaluation disposition in the U.S.

If you are selecting answers for D2a: Evaluation disposition in U.S., please make sure to indicate an Evaluation disposition date (D1a) as this is required for data entry into EDN in this circumstance.

## 6.2 D2 – Evaluation Disposition in U.S.

The three possible evaluation endpoints are 'Completed evaluation,' 'Initiated evaluation/not completed,' and 'Did not initiate evaluation.' **Please indicate only ONE of these selections if you are filling out this section**. It is acceptable to select one of these options, and later select a different option upon sending an updated form, but please clearly indicate which selection is most current.

If the arriver has not been seen by a medical provider, please select "Did not initiate evaluation".

**COMPLETED EVALUATION**

Checking this box indicates that a domestic TB follow-up evaluation has been completed for an arriving immigrant or refugee for whom a final TB diagnosis has been made.

If this box is checked, please make sure to indicate whether or not treatment is recommended. **This is a requirement for data entry in EDN in this circumstance.**

If treatment is recommended, please indicate whether treatment is recommended for LTBI or active TB (**This is a requirement for data entry in EDN**

**in this circumstance**), and make sure to also complete sections D3 (Diagnosis) and E (U.S. Treatment).

If treatment is not recommended, section E (U.S. Treatment) should not be completed.

**INITIATED EVALUATION/NOT COMPLETED**

Checking this box indicates that a domestic TB follow-up had been initiated for an arriving immigrant or refugee for whom initial screenings for TB were done. However, screenings were not completed or a final TB diagnosis could not be made because of one of the following reasons:

Lost to follow-up – The arriver failed to return to complete the evaluation.

Refused evaluation

Moved within U.S., transferred to: - The arriver moved to another EDN jurisdiction before an evaluation could be completed. **Make sure to notify DOH of arriver's new address so the record can be transferred to the new jurisdiction. You can notify DOH by secure email at tbservices@doh.wa.gov.**

Moved outside U.S. – The arriver returned to the country of origin prior to completion of the evaluation.

Died

Other, specify – For reasons other than those stated previously, the evaluation was not completed. Specify the reason in the space provided or in Section H: Comments.

**DID NOT INITIATE EVALUATION**

**If you have selected the box for 'Did not initiate evaluation,' all of Section C (U.S. Evaluation) should be left blank.**

Checking this box indicates that a domestic evaluation for TB has not been started for the arriving immigrant or refugee because of one of the following reasons:

Not located – Check this box ONLY for evaluations that have not been started. The local health jurisdiction is responsible for determining when all resources have been exhausted in search of the arriver.

Lost to follow-up – The arriver was located but failed to report for initial TB screening at the clinic, and subsequent attempts to contact have failed.

Refused evaluation

Moved within US, transferred to: - Although the arriver was located, an evaluation was not initiated because he or she relocated to another jurisdiction. **Make sure to notify DOH of arriver's new address so the record can be transferred to the new jurisdiction. You can notify DOH by secure email at tbservices@doh.wa.gov.**

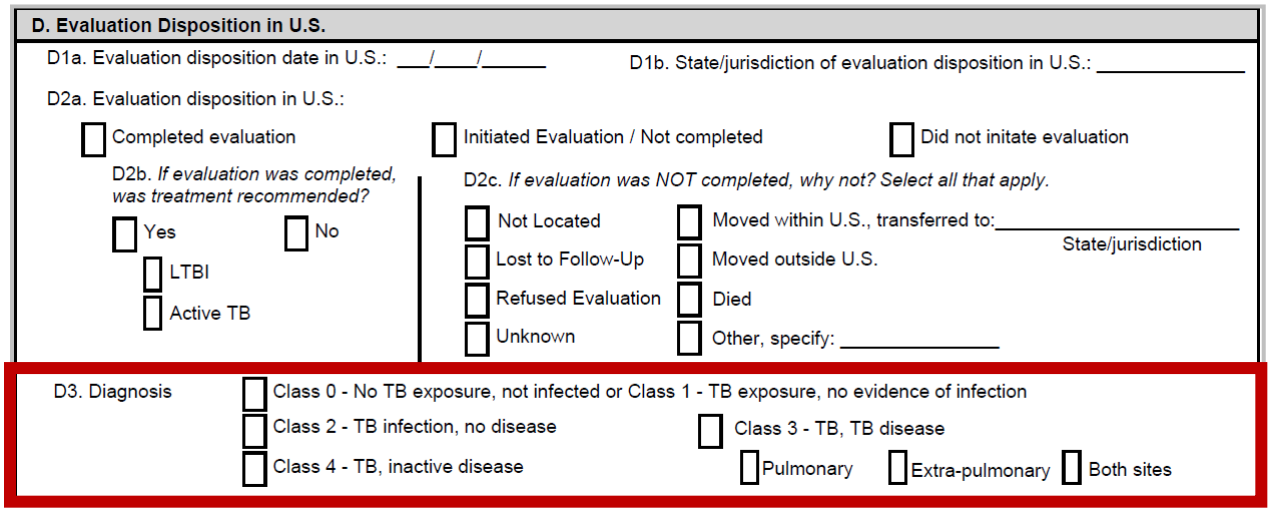
Moved outside U.S. – The arriver returned to the country of origin prior to initiation of evaluation.

Died

Unknown – The evaluation was not started for unknown reasons.

Other, specify – An evaluation was not initiated for reasons other than those stated above. Specify the reason in the space provided or in Section H: Comments.

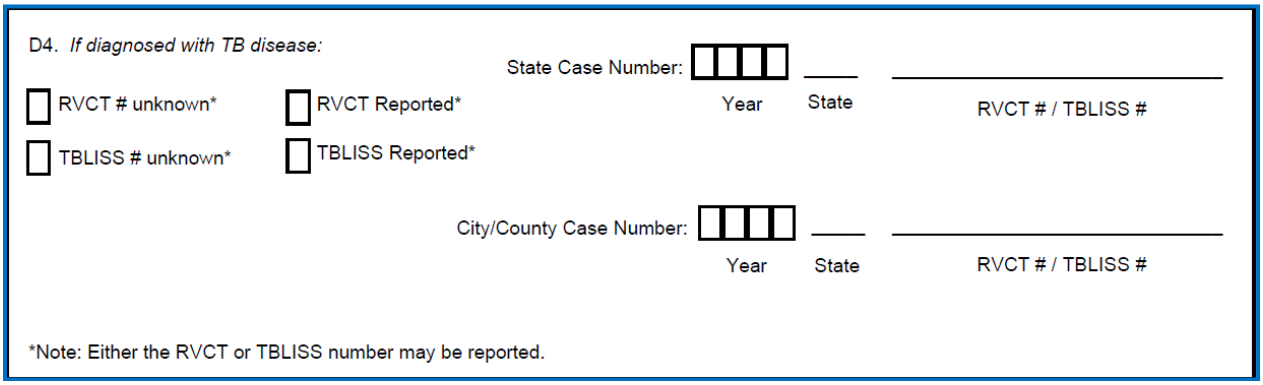
## 6.3 D3 – Diagnosis




Please note that this section refers to the arriver's **domestic** TB diagnosis. Only one selection can be made for this section.

| Classification | Description | Comments |
|---|---|---|
| **Class 0: No TB exposure, not infected** | No TB exposure | • Negative reaction to TST or IGRA<br>• No history of exposure |
| **Class 1: TB exposure, no evidence of infection** | Exposure to TB but not latent TB infection | • Negative reaction to TST or IGRA<br>• No evidence of infection<br>• History of exposure to TB but negative reaction to TST |
| **Class 2: TB infection, no disease** | Latent TB infection (LTBI) | • Positive reaction to TST<br>• Negative microscopy/bacteriology results<br>• No clinical or radiographic evidence of TB |
| **Class 3: TB, active disease** | Active TB disease | • Clinically active TB<br>• Person must have clinical and/or radiologic evidence of TB<br>  ○ Established most definitively by isolation of *M. tuberculosis*<br>  ○ In absence of a positive culture for *M. tuberculosis*, persons in this class must have a positive reaction to the tuberculin test<br>• Class 3 is further defined as pulmonary, extrapulmonary, or in both sites on the follow-up form. **Answering this section is required for data entry into EDN if you have selected Class 3.** |
| **Class 4: TB, inactive disease** | Old, healed, inactive TB disease | • History of previous episode(s) of tuberculosis or abnormal stable radiographic findings<br>• Positive reaction to TST<br>• Negative microscopy/bacteriology<br>• No clinical and/or radiographic evidence of current disease |

## 6.4 D4 – RVCT/TBLISS Reporting

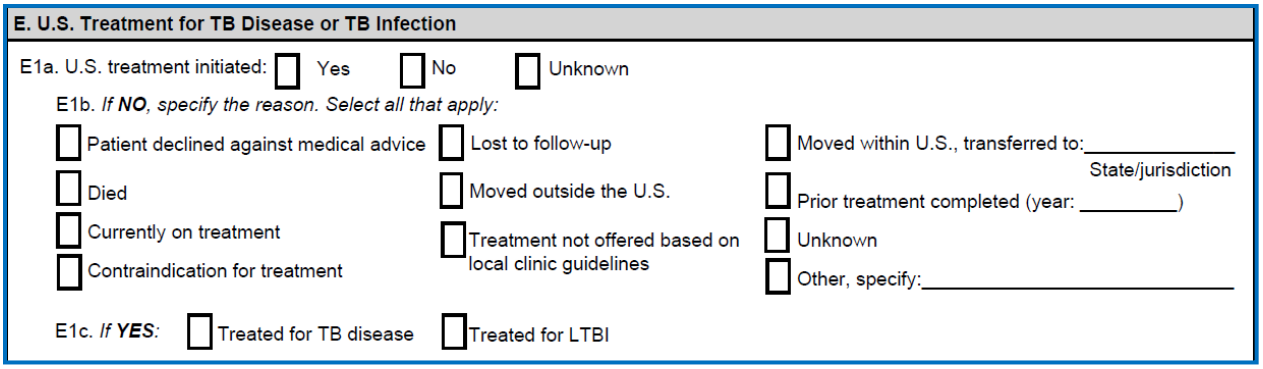



If appropriate and available, enter the RVCT# or TBLISS# for this person, if those records exist. **Unless this information is available for a patient, this section is not required to be completed.**

# 7 Section E: U.S. Treatment for TB Disease or TB Infection

Please note that Section E collects information on **domestic** TB treatment. Section E should be filled out only if treatment was recommended for an arriver with a Class 2, 3, or 4 classification (indicated in section D3 on form)

## 7.1 E1 – U.S. Treatment Initiated




E1a: Indicate whether U.S. treatment was initiated.

If 'Yes,' indicate in E1c whether treatment was initiated for TB disease or LTBI. **This is a requirement for data entry in EDN in this circumstance.** Continue to question E2.

If 'No,' indicate the reason treatment was not initiated in section E1b and move on to Section F. **Please note that more than one selection can be marked for E1b (Select all that apply).**

Patient declined against medical advice

Lost to follow-up – means that the arriver did not report for TB treatment, and subsequent attempts to contact the arriver have failed.

Moved within U.S., transferred to: - means the arriver moved to another jurisdiction. If selected, indicate the jurisdiction to which the arriver moved.

Died

Moved outside the U.S.

Prior treatment completed – please indicate year, if known.

Currently on treatment

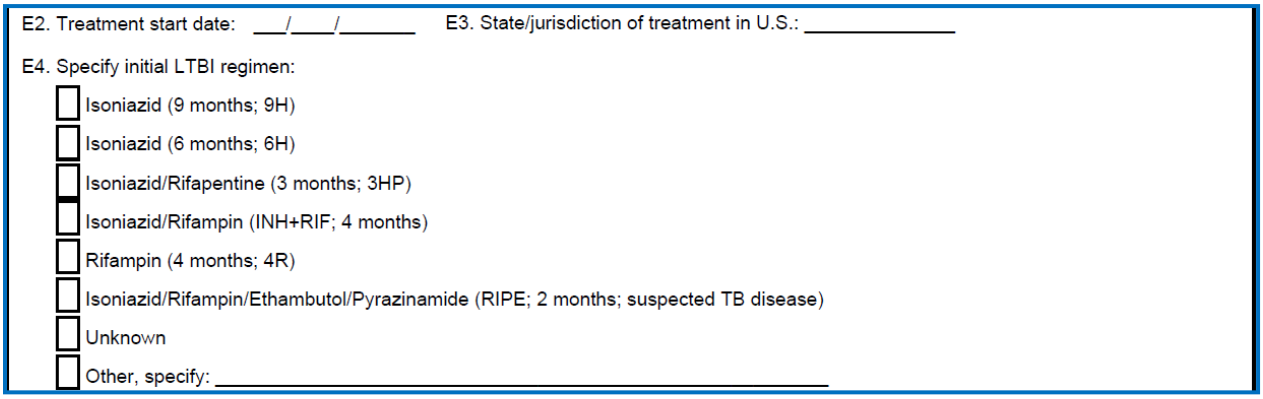
Treatment not offered based on local clinic guidelines

Unknown

Contraindication for treatment

Other, specify – means the arriver did not initiate treatment for reasons other than specified above.

## 7.2 E2, E3, E4 – U.S. Treatment Start


E2. Treatment start date: ___/___/_____ E3. State/jurisdiction of treatment in U.S.: _____

E4. Specify initial LTBI regimen:

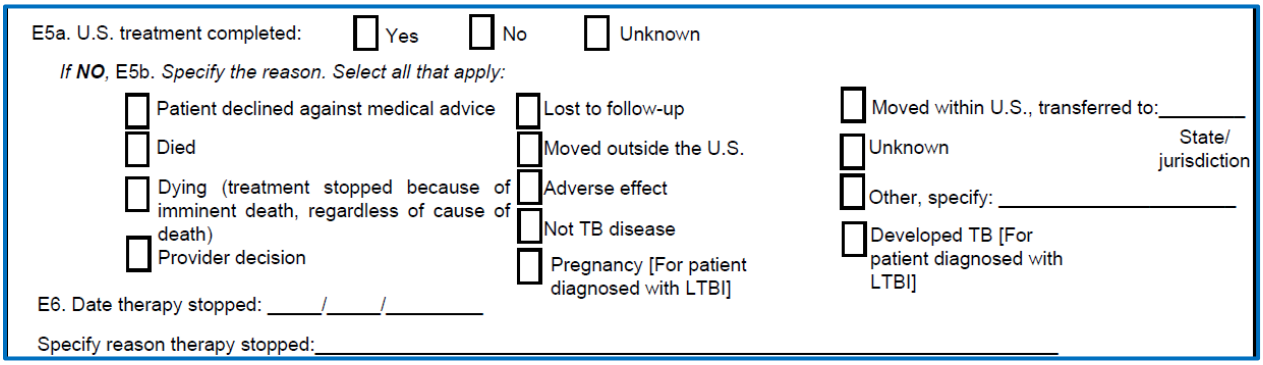
- ☐ Isoniazid (9 months; 9H)
- ☐ Isoniazid (6 months; 6H)
- ☐ Isoniazid/Rifapentine (3 months; 3HP)
- ☐ Isoniazid/Rifampin (INH+RIF; 4 months)
- ☐ Rifampin (4 months; 4R)
- ☐ Isoniazid/Rifampin/Ethambutol/Pyrazinamide (RIPE; 2 months; suspected TB disease)
- ☐ Unknown
- ☐ Other, specify: _____

E2: If U.S. treatment was initiated, indicate treatment start date.

E3: If U.S. treatment was initiated, indicate state/jurisdiction of treatment in U.S.

E4: If U.S. treatment was initiated for LTBI, indicate the initial LTBI regimen. If regimen is not listed, select 'Other, specify' and indicate the regimen initiated.

## 7.3 E5, E6 – U.S. Treatment Completion




E5a: Indicate whether U.S. treatment was completed.

If 'Yes,' proceed to E6 and enter treatment completion date.

If 'No,' indicate the reason for not completing treatment in section E5b, and proceed to E6 and enter treatment end date. **Please note that more than one selection can be marked for E5b (Select all that apply).** If you would like to include additional details regarding the reason therapy stopped, you may do so in the space below E6 labeled 'Specify reason therapy stopped'.

Patient declined against medical advice

Lost to follow-up

Moved within U.S., transferred to: - indicate jurisdiction to which the arriver moved.

Died

Moved outside the U.S.

Unknown – means that treatment was **not** completed, for unknown reasons.

Dying (treatment stopped because of imminent death, regardless of cause of death)

Adverse effect – means treatment was permanently stopped because of an adverse event due to anti-TB medications.

Other, specify: - means that treatment was not completed for reasons other than those listed above.

Provider decision – means that treatment was stopped by the provider for reasons other than adverse effects.

Not TB disease

Pregnancy (for arriver diagnosed with LTBI)

Developed TB (for arriver diagnosed with LTBI)

E6: If therapy was successfully completed, enter the treatment completion date here. If treatment was not successfully completed, enter the date therapy was stopped and ensure you have marked a reason for therapy incompletion in E1b above. If you would like to include additional details regarding the reason therapy stopped, you may do so in the space below E6 labeled 'Specify reason therapy stopped'.

# 8 Sections F and G: Evaluation Site/Treatment Site Information

| F. Evaluation Site Information | G. Treatment Site Information |
|---|---|
| Provider's Name:<br>Clinic Name:<br>Telephone Number: | Provider's Name:<br>Clinic Name:<br>Telephone Number:<br>☐ Same as evaluation site information |

Section F and G contain information about where the arriver was evaluated and treated (if applicable). EDN does not collect the physician's signature.

Provider's name – The name of the provider who performed the U.S. medical evaluation/treatment

Clinic name – The name of the clinic where the arriver was evaluated/treated

Telephone number – Clinic phone number

**Section F refers to the contact information for the provider who screened the patient for LTBI or TB disease. Section G refers to the contact information for the provider who treated the patient diagnosed with LTBI or TB disease (if applicable). If these are the same provider, you may fill out Section F, and then select the box in Section G that says 'Same as evaluation site information'.**

# 9 Section H: Comments

| H. Comments |
|---|
| |

Please include here any important information or clarifications that could not be captured in other sections of the worksheet.