

Patient's Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_ REPORT OF VERIFIED CASE OF TUBERCULOSIS

Street Address: (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip code) \_\_\_\_\_

## REPORT OF VERIFIED CASE OF TUBERCULOSIS

DOH 343-232 November 2022

### ADMINISTRATIVE INFORMATION

<b>Date reported/LHJ notification date:</b> Month    Day    Year <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:40px; height:20px;" type="text"/>	<b>State Case Number:</b> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/>
	<b>Local Case Number:</b> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/>
<b>Countable case?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No, counted by another US reporting area State case number from other area: <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input type="checkbox"/> No, treatment initiated in another country (Specify country: _____) <input type="checkbox"/> No, recurrent TB within 12 months after completion of therapy Prior state case number: <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input type="checkbox"/> No, not a verified case of TB	

### DEMOGRAPHICS AND INITIAL EVALUATION

<b>Reporting Address</b> City: _____ Within city limits: (select one) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown County: _____ Zip Code: _____			
<b>Date of Birth:</b> Month    Day    Year <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:40px; height:20px;" type="text"/> <i>(Enter '99' for unknown month or day or '9999' for unknown year)</i>	<b>Sex assigned at birth:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<b>Was patient pregnant at time of diagnostic evaluation?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Ethnicity:</b> <input type="checkbox"/> Hispanic, Latino/a, Latinx <input type="checkbox"/> Non-Hispanic, Latino/a, Latinx <input type="checkbox"/> Unknown <input type="checkbox"/> Patient declined to respond
<b>Race: (Select all that apply)</b> <input type="checkbox"/> Patient declined <input type="checkbox"/> Unknown <input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Asian Specify: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Bhutanese <input type="checkbox"/> Burmese <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Hmong <input type="checkbox"/> Indonesian <input type="checkbox"/> Iwo Jiman <input type="checkbox"/> Japanese <input type="checkbox"/> Karen <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Madagascar <input type="checkbox"/> Malaysian <input type="checkbox"/> Maldivian <input type="checkbox"/> Mien <input type="checkbox"/> Nepalese <input type="checkbox"/> Okinawan <input type="checkbox"/> Pakistani <input type="checkbox"/> Singaporean <input type="checkbox"/> Sri Lankan <input type="checkbox"/> Taiwanese <input type="checkbox"/> Thai <input type="checkbox"/> Vietnamese <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander Specify: <input type="checkbox"/> Carolinian <input type="checkbox"/> Chamorro <input type="checkbox"/> Chuukese <input type="checkbox"/> Fijian <input type="checkbox"/> Guamanian <input type="checkbox"/> Kiribati <input type="checkbox"/> Kosraean <input type="checkbox"/> Mariana Islander <input type="checkbox"/> Marshallese <input type="checkbox"/> Melanesian <input type="checkbox"/> Micronesian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> New Hebrides <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Palauan <input type="checkbox"/> Papua New Guinean <input type="checkbox"/> Pohnpeian <input type="checkbox"/> Polynesian <input type="checkbox"/> Saipanese <input type="checkbox"/> Samoan <input type="checkbox"/> Solomon Islander <input type="checkbox"/> Tahitian <input type="checkbox"/> Tokelauan <input type="checkbox"/> Tongan <input type="checkbox"/> Yapese <input type="checkbox"/> White <input type="checkbox"/> Other Race Not Listed Above Specify: <input type="checkbox"/> Afghan <input type="checkbox"/> Afro-Caribbean <input type="checkbox"/> Arab <input type="checkbox"/> Central American <input type="checkbox"/> Cham <input type="checkbox"/> Chicano/a or Chicanx <input type="checkbox"/> Congolese <input type="checkbox"/> Cuban <input type="checkbox"/> Dominican <input type="checkbox"/> Egyptian <input type="checkbox"/> Eritrean <input type="checkbox"/> Ethiopian <input type="checkbox"/> First Nations <input type="checkbox"/> Indigenous-Latino/a or Latinx <input type="checkbox"/> Iranian <input type="checkbox"/> Iraqi <input type="checkbox"/> Jordanian <input type="checkbox"/> Kenyan <input type="checkbox"/> Kuwaiti <input type="checkbox"/> Lebanese <input type="checkbox"/> Mestizo <input type="checkbox"/> Mexican/Mexican-American <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Moroccan <input type="checkbox"/> North African <input type="checkbox"/> Oromo <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Romanian/Rumanian <input type="checkbox"/> Russian <input type="checkbox"/> Saudi Arabian <input type="checkbox"/> Somali <input type="checkbox"/> South African <input type="checkbox"/> South American <input type="checkbox"/> Syrian <input type="checkbox"/> Ugandan <input type="checkbox"/> Ukrainian <input type="checkbox"/> Yemeni <input type="checkbox"/> Other (Specify: _____)			

Patient's Name: \_\_\_\_\_

State Case ID: \_\_\_\_\_

**DEMOGRAPHICS AND INITIAL EVALUATION** *(continued)*

Country of birth: \_\_\_\_\_

If NOT United States or U.S. territory, date of first U.S. Arrival:

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

*(Enter '99' for unknown month or day or '9999' for unknown year)*

Eligible for U.S. citizenship/ nationality at birth (regardless of country of birth)?

- Yes  
 No  
 Unknown

Countries of birth for primary guardians:  
*(For pediatric cases only)*

Guardian 1: \_\_\_\_\_

Guardian 2: \_\_\_\_\_

Preferred language: \_\_\_\_\_

Country of usual residence:

\_\_\_\_\_

If NOT U.S. reporting area, has been in US for ≥ 90 days (inclusive of report date)?

- Yes  No  Unknown

Initial reason evaluated for TB:

- |  |  |
|--|--|
| <input type="checkbox"/> Contact investigation             | <input type="checkbox"/> TB symptoms               |
| <input type="checkbox"/> Targeted testing                  | <input type="checkbox"/> Abnormal chest radiograph |
| <input type="checkbox"/> Health care worker                | <input type="checkbox"/> Incidental lab result     |
| <input type="checkbox"/> Employment/administrative testing | <input type="checkbox"/> Unknown                   |
| <input type="checkbox"/> Immigration medical exam          | <input type="checkbox"/> Other (Specify: _____)    |

Status at TB diagnosis:  Alive  Dead

**RISK FACTORS**

Has patient ever worked as one of the following?  
*(Select all that apply)*

- Healthcare worker  
 Correctional facility employee  
 Migrant/seasonal worker  
 None of the above  
 Unknown

Patient's current occupation(s) and industry(ies):  
*(See reference manual for detailed instructions)*

Occupation	Industry
<i>Ex: Registered Nurse</i>	<i>Ex: Hospital</i>

Other risk factors: *(Select all that apply)*

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| Yes                      | No                       | Unk                      |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetic at diagnostic evaluation                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Has experienced homelessness in the past 12 months           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Has experienced homelessness ever                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Resident of correctional facility at diagnostic evaluation   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Resident of correctional facility ever                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Resident of long-term care facility at diagnostic evaluation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Injecting drug use in the past 12 months                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Noninjecting drug use in the past 12 months                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heavy alcohol use in the past 12 months                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | TNF-α antagonist therapy                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Post-organ transplantation                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | End stage renal disease                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Viral hepatitis (B or C only)                                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other immunocompromise (other than HIV/AIDS)                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other risk factor(s) (Specify: _____)                        |

If resident of correctional facility at diagnostic evaluation, type of facility?

- Federal prison  
 State prison  
 Local jail  
 Juvenile correctional facility  
 Other correctional facility  
 Unknown

If resident of long-term care facility at diagnostic evaluation, type of facility?

- Nursing home  
 Hospital-based facility  
 Residential facility  
 Mental health residential facility  
 Alcohol or drug treatment facility  
 Other long-term care facility  
 Unknown

Current smoking status at diagnostic evaluation:

- Current every day smoker  
 Current some day smoker  
 Former smoker  
 Never smoker  
 Smoker, current status unknown  
 Unknown if ever smoked

Lived outside of the United States for > 2 months (uninterrupted)?

- Yes  
 No  
 Unknown

If YES, specify country(ies):  
*(Optional)*

\_\_\_\_\_  
\_\_\_\_\_

Patient's Name: \_\_\_\_\_

State Case ID: \_\_\_\_\_

**DIAGNOSTIC TESTING (NON-DST)**

**Tuberculin skin test and all non-DST TB laboratory test results:** (Required results prefilled in table; unlimited number of additional results may be entered. If test not done, indicate so.)

Test type	Specimen source site	Date collected/placed	Date reported/read	Test result (qual.)	Test result (quant.)	Test results (units of measure)
TST	Skin					Mm
IGRA [specify type]	Blood					N/A
Smear					N/A	N/A
Culture					N/A	N/A
NAA					N/A	N/A
HIV	Blood				N/A	N/A
CD4 count						
Hemoglobin A1c						
Fasting blood glucose						
Other (Specify: _____)						

**Test type options:** Smear, Pathology, Cytology, NAA, Culture, TST, IGRA-QFT, IGRA-TSpot, IGRA-Other, IGRA-Unknown, HIV, CD4 Count, Hemoglobin A1c, Fasting blood glucose, Other (Specify)  
**Test result (qualitative) options:** Positive, Negative, Indeterminate, Not done, Unknown, Refused, Test done result unknown, Not offered  
**Test result (units of measure) options:** Millimeters of induration (TST), Cell count (CD4), Percentage (HGB-A1c), Milligrams per deciliter (FBG), Other units as appropriate

**Chest radiograph or other chest imaging study results:** (Required results prefilled in table; unlimited number of additional results may be entered. If test not done, indicate so.)

Study type	Date of study	Result	Cavity?	Miliary?
Plain chest X-Ray				
CT scan				

**Study type options:** Plain chest X-ray, CT scan, MRI, PET, Other  
**Result options:** Not consistent with TB, Consistent with TB, Not done, Unknown  
**Cavity options:** Yes, No, Unknown  
**Miliary Options:** Yes, No, Unknown

**CLINICAL HISTORY AND FINDINGS**

Has the patient been previously diagnosed with TB disease or LTBI?

- Yes
- No
- Unknown

If YES, complete table to the right  
(Unlimited number of rows may be entered)

Diagnosis type (TB disease / LTBI)	Date of diagnosis	Previous state case number	Completed treatment? (Yes/No/Unknown)

Date of illness onset/symptom start date:

Month    Day    Year

--	--	--	--	--	--

(Enter '99' for unknown month or day or '9999' for unknown year)

Site of TB disease: (Select all that apply)

- Pulmonary/Lung Structure
- Pleural
- Lymphatic: Cervical
- Lymphatic: Intrathoracic
- Lymphatic: Axillary
- Lymphatic: Other
- Lymphatic: Unknown
- Laryngeal
- Bone, Joint, and/or Soft Tissue
- Other (Specify: \_\_\_\_\_)
- Genitourinary
- Meningeal
- Peritoneal
- Site not stated

Patient's Name: \_\_\_\_\_

State Case ID: \_\_\_\_\_

**EPIDEMIOLOGIC INVESTIGATION**

Case meets binational reporting criteria?

- Yes
- No
- Unknown

If YES, which criteria were met? (Select all that apply)

- Exposure to suspected product from Canada or Mexico (e.g., dairy product for *M. bovis* case)
- Has case contacts in or from Mexico or Canada
- Potentially exposed by a resident of Mexico or Canada
- Potentially exposed while in Mexico or Canada
- Resident of Canada or Mexico
- Other situations that may require binational notification or coordination of response

Case identified during the contact investigation of another case?

- Yes
- No
- Unknown

If YES, evaluated for TB during that contact investigation?

- Yes
- No
- Unknown

Contact investigation conducted for this case?

- Yes
- No
- Unknown

Were contacts identified?

- Yes
- No
- Unknown

Complete table below for all known TB and LTBI cases epidemiologically linked to this case  
(An unlimited number of rows may be entered in WDRS)

State case number (RVCT #)
2020-WA-999999999

Known exposure(s): (Optional)

- Contact of MDR TB Patient (2 years or less)
- Contact of infectious TB patient (2 years or less)

**INITIAL TREATMENT INFORMATION**

Date therapy started:

(See RVCT Instruction Manual for hierarchy to determine date therapy started)

Month	Day	Year
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Initial drug regimen:

- | Yes                      | No                       | Unk                      |                        | Yes                      | No                       | Unk                      |
|--------------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Isoniazid              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rifampin               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pyrazinamide           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ethambutol             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Streptomycin           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rifabutin              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rifapentine            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ethionamide            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Amikacin               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kanamycin              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Capreomycin            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ciprofloxacin          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other (Specify: _____) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If initial drug regimen NOT RIPE/HRZE (Rifampin, Isoniazid, Pyrazinamide, and Ethambutol) why not?  
(Select one)

- Drug contraindication/interaction
- Drug susceptibility testing results already known
- Suspected drug resistance
- Drug shortage
- Other (Specify: \_\_\_\_\_)
- Unknown

Anticipated treatment duration: (Optional)

- 4 months
- 6 months
- 9 months
- Other, (Specify: \_\_\_\_\_)
- 12 months
- 18 months
- 24 months

Patient's Name: \_\_\_\_\_

State Case ID: \_\_\_\_\_

**INITIAL TREATMENT INFORMATION (continued)**

Was phenotypic/growth-based drug susceptibility testing done?  Yes  No  Unknown

If YES, complete table below (An unlimited number of rows may be entered)  
Include initial result for all drugs listed as well as any subsequent tests where results changed

Drug name	Date collected	Date reported	Specimen source	Result
Isoniazid				
Rifampin				
Pyrazinamide				
Ethambutol				
Streptomycin				
Rifabutin				
Rifapentine				
Ethionamide				
Amikacin				
Kanamycin				
Capreomycin				
Ciprofloxacin				
Levofloxacin				
Ofloxacin				
Moxifloxacin				
Other Quinolones				
Cycloserine				
Para-Amino Salicylic Acid				
Linezolid				
Bedaquiline				
Delamanid				
Clofazimine				
Pretomanid				
Other (Specify: _____)				

**Result Options:** Resistant, Susceptible, Not done, Unknown

Was genotypic/molecular drug susceptibility testing done?  Yes  No  Unknown

If YES, complete table below (an unlimited number of rows may be entered)  
Include initial result for each combination of gene and test type as well as any subsequent tests where the result changed

Gene name	Date collected	Date reported	Specimen source	Result	Nucleic acid change	Amino acid change	INDEL	Test type

**Results options:** Mutation detected, Mutation not detected, Unknown **Indel options:** Insertion, Deletion, Indel (not otherwise specified), Unknown  
**Test type options:** Nonsequencing, Sequencing, Other, Unknown

Was the patient treated as an MDR TB case (regardless of DST results)?  Yes  No  Unknown

If YES, complete MDR TB Supplemental Data Form

Patient's Name: \_\_\_\_\_

State Case ID: \_\_\_\_\_

**CASE OUTCOME**

**Sputum culture conversion documented?**

- Yes
- No
- Unknown

If YES, date specimen collected for FIRST consistently negative sputum culture:

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

**If NO, reason for not documenting sputum culture conversion?**

- No follow-up sputum despite induction
- No follow-up sputum and no induction
- Died
- Patient refused
- Patient lost to follow-up
- Other (Specify: \_\_\_\_\_)
- Unknown

**Moved during therapy?**

- Yes
- No
- Unknown

**If YES, moved to where? (Select all that apply)**

- In-State (out of jurisdiction)  
(Specify County/City: \_\_\_\_\_)
- Out of State  
(Specify destination: \_\_\_\_\_)
- Out of United States  
(Specify destination: \_\_\_\_\_)
- Transnational referral made?
  - Yes
  - No
  - Unknown

**Date therapy stopped:** (See RVCT Instruction Manual for hierarchy to determine date therapy stopped)

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Reason therapy stopped or never started? (Select one)**

- Completed treatment
- Lost
- Patient choice (uncooperative or refused)
- Adverse treatment event
- Not TB
- Died
- Dying (treatment stopped because of imminent death, regardless of cause of death)
- Other (Specify: \_\_\_\_\_)
- Unknown

**Reason TB disease therapy extended >12 months, if applicable:**

(Select all that apply)

- Inability to use Rifampin (resistance, intolerance, etc.)
- Adverse drug reaction
- Nonadherence
- Failure
- Clinically indicated for reasons other than above
- Other (Specify: \_\_\_\_\_)
- Unknown

**Treatment administration: (Select all that apply)**

- DOT (Directly Observed Therapy, in person)
- EDOT (Electronic DOT, via video call or other electronic method)
- Self-administered

**Did the patient die (either before diagnosis or at any time while being followed by TB program)?**

- Yes
- No
- Unknown

**If YES, date of death:**

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Did TB or complications of TB treatment contribute to death?**

- Yes
- No
- Unknown

**Type of outpatient healthcare provider: (Optional)**

- |  |   |
|--|---|
| <input type="checkbox"/> Local/state health department         | <input type="checkbox"/> Institutional/correctional |
| <input type="checkbox"/> Private outpatient                    | <input type="checkbox"/> Inpatient care only        |
| <input type="checkbox"/> IHS, Tribal HD, or Tribal Corporation | <input type="checkbox"/> Unknown                    |
| <input type="checkbox"/> Other (Specify: _____)                |   |