

# CASE REPORT FORM

# Tuberculosis

	EpiSurv No. <input style="width: 50px;" type="text"/>
<b>Disease Name</b> <span style="float: right;">?</span>	
<input type="radio"/> Tuberculosis disease - new case <span style="margin-left: 200px;"><input type="radio"/> Tuberculosis disease - relapse or reactivation</span> <input type="radio"/> Latent tuberculosis infection (patient consent required) <span style="margin-left: 200px;"><input type="radio"/> Tuberculosis infection - old disease on preventive treatment (fully investigated and active disease excluded)</span>	
<b>Reporting Authority</b>	
Name of Public Health Officer responsible for case <input style="width: 80%;" type="text"/>	
<b>Notifier Identification</b> <span style="float: right;">?</span>	
<b>Reporting source*</b> <input type="radio"/> General Practitioner <input type="radio"/> Hospital-based Practitioner <input type="radio"/> Laboratory <input type="radio"/> Self-notification <input type="radio"/> Outbreak Investigation <input type="radio"/> Other	
Name of reporting source <input style="width: 150px;" type="text"/> Organisation <input style="width: 150px;" type="text"/>	
<b>Date reported*</b> <input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/> <b>Laboratory sample date</b> <input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/> <b>Contact phone</b> <input style="width: 100px;" type="text"/>	
<b>Usual GP</b> <input style="width: 100px;" type="text"/> <b>Practice</b> <input style="width: 100px;" type="text"/> <b>GP phone</b> <input style="width: 100px;" type="text"/>	
<b>GP/Practice address</b> Number <input style="width: 50px;" type="text"/> Street <input style="width: 100px;" type="text"/> Suburb <input style="width: 100px;" type="text"/> Town/City <input style="width: 150px;" type="text"/> Post Code <input style="width: 50px;" type="text"/> <input type="checkbox"/> GeoCode <input style="width: 50px;" type="text"/>	
<b>Case Identification</b> <span style="float: right;">?</span>	
<b>Name of case*</b> Surname <input style="width: 150px;" type="text"/> Given Name(s) <input style="width: 150px;" type="text"/>	
<b>NHI number*</b> <input style="width: 50px;" type="text"/> <b>Email</b> <input style="width: 150px;" type="text"/>	
<b>Current address*</b> Number <input style="width: 50px;" type="text"/> Street <input style="width: 100px;" type="text"/> Suburb <input style="width: 100px;" type="text"/> Town/City <input style="width: 150px;" type="text"/> Post Code <input style="width: 50px;" type="text"/> <input type="checkbox"/> GeoCode <input style="width: 50px;" type="text"/>	
<b>Phone (home)</b> <input style="width: 100px;" type="text"/> <b>Phone (work)</b> <input style="width: 100px;" type="text"/> <b>Phone (other)</b> <input style="width: 100px;" type="text"/>	
<b>Case Demography</b>	
<b>Location TA*</b> <input style="width: 150px;" type="text"/> <b>DHB*</b> <input style="width: 150px;" type="text"/>	
<b>Date of birth*</b> <input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/> <b>OR</b> <b>Age</b> <input style="width: 50px;" type="text"/> <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years	
<b>Sex*</b> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Indeterminate <input type="radio"/> Unknown	
<b>Occupation*</b> <input style="width: 150px;" type="text"/> <span style="float: right;">?</span>	
<b>Occupation location</b> <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school	
<b>Name</b> <input style="width: 150px;" type="text"/>	
<b>Address</b> Number <input style="width: 50px;" type="text"/> Street <input style="width: 100px;" type="text"/> Suburb <input style="width: 100px;" type="text"/> Town/City <input style="width: 150px;" type="text"/> Post Code <input style="width: 50px;" type="text"/> <input type="checkbox"/> GeoCode <input style="width: 50px;" type="text"/>	
<b>Alternative location</b> <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school	
<b>Name</b> <input style="width: 150px;" type="text"/>	
<b>Address</b> Number <input style="width: 50px;" type="text"/> Street <input style="width: 100px;" type="text"/> Suburb <input style="width: 100px;" type="text"/> Town/City <input style="width: 150px;" type="text"/> Post Code <input style="width: 50px;" type="text"/> <input type="checkbox"/> GeoCode <input style="width: 50px;" type="text"/>	
<b>Ethnic group case belongs to*</b> (tick all that apply) <span style="float: right;">?</span>	
<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) <input style="width: 100px;" type="text"/>	

**Basis of Diagnosis****LABORATORY CRITERIA** ?

- Meets laboratory criteria for disease\***  Yes  No  Unknown
- Demonstration of acid-fast bacilli in a clinical specimen**  Yes  No  Not Done  Awaiting Results  
If yes, specify site  Sputum  Other (specify)
- Isolation of Mycobacterium tuberculosis, or M. bovis from a clinical specimen**  Yes  No  Not Done  Awaiting Results  
If yes, specify site  Sputum  Other (specify)
- Demonstration of M. tuberculosis nucleic acid (PCR or LCR only)**  Yes  No  Not Done  Awaiting Results  
If yes, specify site  Sputum  Other (specify)
- Histology strongly suggestive of tuberculosis**  Yes  No  Not Done  Awaiting Results

**MANTOUX STATUS**

- Mantoux tests done\***  Yes  No  Awaiting Results  Unknown
- Date\***  **mm induration\***  mm **Date\***  **mm induration\***  mm
- Mantoux status\*** (tick most appropriate - must use definitions in TB guidelines)  
 Mantoux Negative  Mantoux Positive  Mantoux Converted  Mantoux Unknown

**IGRA STATUS**

- Test done\***  Yes  No  Awaiting Results  Unknown  
If yes, result  Positive  Negative  Indeterminate

**OTHER CRITERIA**

- Treatment for presumptive TB\***  Yes  No  Unknown
- Interim treatment for presumptive LTBI in children < 5 years\***  Yes  No  Unknown

- CLASSIFICATION\***  Under investigation  Probable - presumptive  Confirmed  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?\***  Yes  No  Unknown
- Was the case treated?\***  Yes  No  Unknown  
If yes, duration of treatment\*  months

**ADDITIONAL CLINICAL DETAILS****Site of disease (disease only)**

- Pulmonary\***  Yes  No
- If yes,  
**Radiology\***  Normal  Active TB  TB of Uncertain Activity  Not Done  Unknown
- Evidence of cavity formation\***  Yes  No  Unknown

**Basis of Diagnosis (continued)**Extrapulmonary\*  Yes  No

If yes, tick all that apply\*

- Lymph node (excl abdomen)  Pleural  MiliaryTB  
 Bone/joint  Intraabdominal (excl renal)  Renal/genitourinary tract  
 Soft tissue/skin  CNS TB (including meningitis)  
 Other site, specify

**How was case/infection discovered?\***

- Contact follow-up  Immigrant/refugee screening  Attended practitioner with symptoms  
 Other (specify)   Unknown

**ADDITIONAL LABORATORY DETAILS (CULTURE POSITIVE CASES ONLY and ESR UPDATED)**

**Mycobacterial species**  *Mycobacterium tuberculosis*  *M. bovis*  
 Other (\*specify)

**Susceptibility testing results**

- Isoniazid (0.1 mg/L)  Susceptible  Resistant  
 Isoniazid (0.4 mg/L)  Susceptible  Resistant  
 Rifampicin  Susceptible  Resistant  
 Ethambutol  Susceptible  Resistant  
 Pyrazinamide  Susceptible  Resistant  
 Streptomycin  Susceptible  Resistant  
 Other antibiotics (specify)  Susceptible  Resistant  
  Susceptible  Resistant  
  Susceptible  Resistant  
  Susceptible  Resistant  
  Susceptible  Resistant  
  Susceptible  Resistant  
  Susceptible  Resistant  
  Susceptible  Resistant

**Specimen details** Date specimen taken  dd/mm/yyyy  Specimen number   
 Updated  Reference laboratory  Date results updated  dd/mm/yyyy

**Molecular Typing**

MIRU  RFLP  ClusterID   
 Updated  Date Results Updated  dd/mm/yyyy  Specimen Number

**Clinical Course and Outcome**

**Date of onset\***  dd/mm/yyyy   Approximate  Unknown  
 Asymptomatic

**Hospitalised\***  Yes  No  Unknown

**Date hospitalised\***  dd/mm/yyyy   Unknown

**Hospital\***

**Clinical Course and Outcome continued**Died\*  Yes  No  UnknownDate died\*   UnknownWas this disease the primary cause of death?\*  Yes  No  UnknownIf 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)?\*

 YesIf yes, specify Outbreak No\* **Risk Factors**Has HIV test been performed\*  Yes  No  UnknownOther immunosuppressive illness (chronic renal failure, alcoholism, diabetes, gastrectomy)\*  Yes  No  UnknownIf yes, specify Immunosuppressive medication\*  Yes  No  UnknownContact with a confirmed case of tuberculosis\*  Yes  No  UnknownIf yes, specify nature of contact\* If yes, did contact occur within New Zealand\*  Yes  No  UnknownIf yes, specify name of case\* Born outside New Zealand\*  Yes  No  UnknownIf yes, specify country of birth\* If yes, date of arrival in NZ\*   UnknownCurrent or recent residence in a household with a person(s) born outside New Zealand\*  Yes  No  UnknownIf yes, specify country of birth\* Exposure in health care setting\*  Yes  No  UnknownIf yes, specify exposure\* Current or recent residence in an institution (e.g. prison)\*  Yes  No  UnknownIf yes, specify details\* Exposure to cattle, deer, possums, other wild animals or animal products in work or recreation\*  Yes  No  Unknown\*If yes, specify exposure in detail 

Other risk factors for tuberculosis\*

(specify\*)

**Protective Factors**

**At any time prior to onset, had the case been immunised with BCG vaccine?\***  Yes  No  Unknown

If yes, specify date given\*   Unknown

If yes, how was this confirmed\*  Scar  Patient/Caregiver recall  Documented  Unknown

**Management****CASE MANAGEMENT**

**Under specialist care\***  Yes  No  Unknown

Name of specialist\*

**Did the case receive treatment?\***  Yes  Treatment declined  Treatment inappropriate  Unknown

If yes

**Date treatment started\***   Unknown

**Date treatment ended in NZ\***   Unknown

**Was treatment interrupted?\***  Yes  No  Unknown

**Reason treatment ended\***

- Tmt completed to the satisfaction of the prescribing doctor  Transferred to overseas medical care
- Went overseas (medical care not transferred or unknown)  Died
- Refused to complete treatment  Stopped treatment because of adverse effects
- Stopped due to pregnancy  Lost to follow up
- Discontinuation of interim treatment for LTBI (child <5 years)  Reason unknown

**Did case receive DOT throughout the intensive phase of treatment?\***  Yes  No  Unknown

**Did case receive DOT throughout the course of treatment?\***  Yes  No  Unknown

**CONTACT MANAGEMENT (disease only)**

**Did case have any contacts at risk of infection?\***  Yes  No  Unknown

*If yes, type of contact:* *Number Identified*

Close contacts\*

Casual contacts\*

**Comments\***