

Name-Last	First	MI
Address-Street	City	State ZIP

Report of Suspected/Verified Case of TB

Ohio Department of Health
Tuberculosis Registry Section
35 East Chestnut Street, 7th floor
Columbus, Ohio 43266-0118

Shaded areas for state and federal use only

SOUDEX

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1 Reporting County	2 State Case #
Date	City/County Case #
month day year	

3 Date Submitted	By:	4 Address for Case Counting
month day year		City
5 Month-Year Reported	6 Month-Year Counted	Within city limits? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
month year	month year	County
7 Date of Birth	8 Sex	9 Ethnicity (select one)
month day year	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
11 Country of Origin	12 Month-Year Arrived in U.S.	10 Race (select one or more)
<input type="checkbox"/> If U.S. check If not U.S. enter country code (see list)	month year	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <i>specify (optional)</i> _____ <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <i>specify (optional)</i> _____ <input type="checkbox"/> White
11 Country of Origin	13 Status at Diagnosis of TB	
	<input type="checkbox"/> Alive <input type="checkbox"/> Dead	

14 Previous Diagnosis of Tuberculosis	15 Major Site of Disease	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list year of previous diagnosis <input type="checkbox"/> Check if more than one previous episode	<input type="checkbox"/> Pulmonary <input type="checkbox"/> Lymphatic: Other <input type="checkbox"/> Miliary <input type="checkbox"/> Site not Stated <input type="checkbox"/> Pleural <input type="checkbox"/> Lymphatic: Unknown <input type="checkbox"/> Meningeal <input type="checkbox"/> Lymphatic: Cervical <input type="checkbox"/> Bone and/or Joint <input type="checkbox"/> Peritoneal <input type="checkbox"/> Lymphatic: Intrathoracic <input type="checkbox"/> Genitourinary <input type="checkbox"/> Other	
Initial Bacteriology: Date Taken	16 Additional Sites of Disease	
month day year Name of Lab	<input type="checkbox"/> Pulmonary <input type="checkbox"/> Lymphatic: Other <input type="checkbox"/> Miliary <input type="checkbox"/> Check if more than one additional site <input type="checkbox"/> Pleural <input type="checkbox"/> Lymphatic: Unknown <input type="checkbox"/> Meningeal <input type="checkbox"/> Lymphatic: Cervical <input type="checkbox"/> Bone and/or Joint <input type="checkbox"/> Peritoneal <input type="checkbox"/> Lymphatic: Intrathoracic <input type="checkbox"/> Genitourinary <input type="checkbox"/> Other	
17 Sputum Smear	18 Sputum Culture	19 Microscopic Exam of Tissue and Other Body Fluids
<input type="checkbox"/> Positive <input type="checkbox"/> Not Done <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Not Done <input type="checkbox"/> Negative <input type="checkbox"/> Pending	<input type="checkbox"/> Positive <input type="checkbox"/> Not Done <input type="checkbox"/> Negative
20 Culture of Tissue and Other Body Fluids	21 Chest X-Ray	
<input type="checkbox"/> Positive <input type="checkbox"/> Not Done <input type="checkbox"/> Negative <input type="checkbox"/> Pending If positive, enter anatomic code(s) (see list)	Date month day year <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Done If Abnormal (Check one) <input type="checkbox"/> Cavitory <input type="checkbox"/> Noncavitory Consistent with TB <input type="checkbox"/> Noncavitory Not Consistent with TB If Abnormal (Check one) <input type="checkbox"/> Stable <input type="checkbox"/> Improving <input type="checkbox"/> Worsening <input type="checkbox"/> Unknown	
22 Tuberculin (Mantoux) Skin Test at Diagnosis		
<input type="checkbox"/> Positive <input type="checkbox"/> Not Done <input type="checkbox"/> Negative If Negative, was patient anergic <input type="checkbox"/> Yes <input type="checkbox"/> No Date month day year If positive, enter duration in mm	Patient has previous significant skin test <input type="checkbox"/> Yes mm _____ <input type="checkbox"/> No	

Reporting TB is required per Administrative Code 3701-3-02 to 3701-3-05. Failure to comply may result in penalties to the individual or agency as outlined in the Ohio Revised Code.

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Report of Suspected/Verified Case of TB

Initial Drug Susceptibility Report

Ohio Department of Health
 Tuberculosis Registry Section
 35 East Chestnut Street, 7th floor
 Columbus, Ohio 43266-0118

Follow-up Report—1

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SOUDEX <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	County Reporting	Year Counted <input type="text"/>	State Case # <input type="text"/>
			City/County Case # <input type="text"/>

Submit this report for all culture-positive cases.

33. Initial Drug Susceptibility Results:

Was Drug Susceptibility Testing Done? Yes No

If Yes, Enter Date Isolate Collected for Which Drug Susceptibility Was Done?

<input type="text"/>					
month	day	year			

If Answer is No or Unknown, Do Not Complete rest of Report.

34. Susceptibility Results:

	Resistant	Susceptible	Not Done
Isoniazid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifampin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pyrazinamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethambutol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Streptomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethionamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kanamycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cycloserine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Capreomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Para-Amino Salicylic Acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amikacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifabutine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments

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Case Completion Report

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Follow-up Report—2

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SOUDEX <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	County Reporting	Year Counted	State Case #
			City/County Case #

35. Sputum Culture Conversion Documented

Yes No

If Yes, Date Specimen Collected on Initial Positive Sputum Culture:

month day year

If Yes, Date Specimen Collected on First Consistently Negative Culture:

month day year

36. Date Therapy Stopped

month day year

37. Reason Therapy Stopped

Completed Therapy Lost Not TB Other

Moved Uncooperative or Refused Died

38. Type of Health Care Provider

Health Department

Private/Other

Both Health Department and Private/Other

39. Directly Observed Therapy

No, Totally Self-Administered

Yes, Totally Directly Observed

Yes, Both Directly Observed and Self-Administered

If Yes, Give Site(s) of Directly Observed Therapy:

In Clinic /Other Facility

In the Field

Both in the Facility and in the Field

Number of Weeks of Directly Observed Therapy:

40. Final Susceptibility Results

Was Follow-up Drug Susceptibility Testing Done? Yes No

If Yes, Enter Date Final Isolate Collected for Which Drug Susceptibility Was Done:

month day year

If Answer is No or Unknown, Do Not Complete rest of Report.

41. Final Drug Susceptibility Results

	Resistant	Susceptible	Not Done		Resistant	Susceptible	Not Done
Isoniazid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Capreomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifampin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Para-Amino Salicylic Acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pyrazinamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amikacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethambutol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rifabutine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Streptomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethionamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kanamycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cycloserine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Comments
