BP-A0665 **TUBERCULOSIS CASE/SUSPECT REPORT AND REFERRAL** CDFRM
MARCH 12
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

Within one working day of suspecting active TB, send by email to Region & Central Office infectious disease email boxes and by fax to local health department. Send updates as data becomes available. Scan updates into BEMR Document Manager as "Flowsheet," "TB Report."

Report Dates: **(1)** __/__/____ **(2)** __/__/____ **(3)** __/__/____ **(4)** __/__/____ **(5)** __/__/____

Staff Initials: **(1)** _____ **(2)** _____ **(3)** _____ **(4)** _____ **(5)** _____

REPORTING INFORMATION

BOP Facility: _____ Address _____ City _____ State ____ ZIP _____

BOP Staff Contact: _____ **Reported to:** _____ **Health Dept. Date:** __/__/____

DEMOGRAPHICS

BOP Reg #: _____ **Inmate Name:** Last _____ First _____ MI ___

Alien (INS) # (SENTRY-pp41)**:** _____ **Inmate Alias:** Last _____ First _____ MI ___

Date of Birth: __/__/____ **Sex at Birth:** ☐Male ☐Female

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino

Country of Birth: ☐U.S.(or born abroad to U.S. parents) ☐_____

Month/Year arrived in U.S. for the first time: __/____

Primary Language: ☐Eng ☐Span ☐_____ **Need interpreter?** ☐Y ☐N

Race: *(select one or more)* ☐American Indian/Alaska Native ☐Asian ☐Black ☐Native Hawaiian/Other Pacific Islander ☐White

Date entered current BOP custody (SENTRY-pp37)**:** __/__/__

Date entered current BOP facility (SENTRY-pp37)**:** __/__/__

Projected release date (SENTRY-pp44)**:** __/__/__ ☐**"Unknown"**

TB HISTORY AND EVALUATION

1. **Reason evaluated for TB disease** (*check all that apply*)**:**
   ☐Inmate being treated for active TB at intake to this facility
   ☐Intake screening ☐TB symptoms ☐Contact to a TB case
   ☐Annual screening ☐Abnormal CXR ☐Other: _____
2. **At time of initial TB report, TB was:** ☐Suspected ☐Confirmed
3. **Status at TB diagnosis:** ☐Alive ☐Dead
4. **4a. Most recent tuberculin skin test(s):** ☐Not tested
   ☐**Tested:** Date: __/__/____ ___mm Date: __/__/____ ___mm
   4b. Interferon gamma release assay (IGRA)**:** ☐Not tested
   ☐**Tested:** Test Type: ☐QuantiFERON ☐T-Spot Date: __/__/____
   Result: ☐Positive ☐Negative ☐Indeterminate
5. **5a. Prior dx of TB disease:** ☐N ☐Y Year? ___ Where?_____
   5b. Prior TLTBI (prophy): ☐N ☐Y Year? ___ Where? _____
6. **TB symptoms** (*check all that apply*)**:** ☐No symptoms observed
   ☐Cough x ___ weeks ☐Productive cough ☐Coughing up blood
   ☐Fever ☐Chills ☐Chest pain ☐Weight loss: ___ lbs in ___ wks
   Comments: _____
   _____
7. **HIV status:** Date tested: ___/___/____ ☐Positive ☐Negative
   ☐Indeterminate ☐Refused ☐Not offered
   If positive: CD4 Date: __/__/____ Result: _____ cells/mm^3
   ART Regimen? ☐N ☐Y Specify: _____
   _____
8. **Other medical conditions:** _____
   _____
   _____
9. **9a. Chest x-ray:** Date __/__/____ ☐Not done
   Result: ☐Neg ☐Abnl (not consistent w/ TB) ☐Abnl (consistent w/ TB)
   Evidence of: Cavity? ☐Y ☐N ☐Unk **Miliary TB?** ☐Y ☐N ☐Unk
   Reading: _____
   _____
   _____
   9b. CT/Other scan: Date __/__/____ ☐Not done
   Result: ☐Neg ☐Abnl (not consistent w/ TB) ☐Abnl (consistent w/ TB)
   Evidence of: Cavity? ☐Y ☐N ☐Unk **Miliary TB?** ☐Y ☐N ☐Unk
   Reading: _____
   _____
   _____
10. **Airborne infection isolation:** ☐Y ☐N
    If yes: Date isolated: __/__/____ Date released: __/__/____
    Where?: ☐BOP facility ☐Hospital: _____

Other pertinent information: _____
_____
_____
_____
_____

11a. TB Risk Factors

Within the past year:

Excess alcohol use**:** ☐Y ☐N ☐Unk
Non-injection drug use: ☐Y ☐N ☐Unk
Injection drug use: ☐Y ☐N ☐Unk
Homeless: ☐Y ☐N ☐Unk
Occupation: _____

11b. Additional TB Risk Factors

Check all that apply:

☐Prior positive TST & no TLTBI (prophy)
☐Incomplete TLTBI (prophy)
☐TNF-α antagonist therapy
☐Post organ transplantation
☐End stage renal disease
☐Diabetes mellitus

***Within the past two years*:**

☐Contact to infectious TB patient
☐Contact of multiple drug resistant TB patient
☐Missed TB contact

☐***No additional TB risk factors***

12a. LABORATORY RESULTS

Date Collected	Lab Accession Number	Specimen Type (sputum, induced sputum, bronch wash, tissue)	AFB Smear				Rapid Test (NAAT/PCR)					Culture				
			Pos	Neg	Date Updated	Initials	Test Type	Pos	Neg	Date Updated	Initials	*MTB* Pos	*MTB* Neg	Other Positive Culture (non-TB mycobacteria)	Date Updated	Initials
			☐	☐				☐	☐			☐	☐			
			☐	☐				☐	☐			☐	☐			
			☐	☐				☐	☐			☐	☐			
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			☐	☐				☐	☐			☐	☐			

12b. Sputum AFB smear conversion date: __/__/____

(Only if at least one initial sputum is AFB smear positive. This date is the first of 3 consistently negative AFB sputum smears.)

Updated: ___/___/____ Initials: _______

12c. Sputum AFB culture conversion documented:

(Only if the initial sputum culture is positive for M.tuberculosis. This date is the first consistently negative AFB sputum culture. The goal is sputum culture conversion within 8 weeks of starting TB treatment.)

☐**Y Date:** __/__/____ ☐**N**

If no, enter reason *(select one):*

- ☐No follow-up sputum, despite sputum induction
- ☐No follow-up sputum and no sputum induction
- ☐Inmate transferred/released
- ☐Inmate refused
- ☐Other ___________________________________
- ☐Unknown

Updated: ___/___/____ Initials: _______

12d. Drug susceptibility done? ☐Y ☐N ☐Unknown

Initial Results					Follow-Up Results (if done)				
Date reported: __/__/__ Lab accession #:____________					Date reported: __/__/____ Lab accession #:____________				
Drug	Susceptible	Resistant	Not Done	Unknown	Drug	Susceptible	Resistant	Not Done	Unknown
Rifampin	☐	☐	☐	☐		☐	☐	☐	☐
Isoniazid	☐	☐	☐	☐		☐	☐	☐	☐
Pyrazinamide	☐	☐	☐	☐		☐	☐	☐	☐
Ethambutol	☐	☐	☐	☐		☐	☐	☐	☐
Streptomycin	☐	☐	☐	☐		☐	☐	☐	☐
	☐	☐	☐	☐		☐	☐	☐	☐
Updated: __/__/___ Initials: ____					Updated: __/__/___ Initials: ____				

12e. Pathology (biopsy) results: Date: __/__/____ Tissue type: ________

Report: ____ Updated: __/__/__ Initials: ____

13. TB TREATMENT

Drug	Date: ___/___/____ Weight: ____ lb ____kg							Date: ___/___/____ Weight: ____ lb ____kg						
	Dose (mg)	Freq.	Date Start	Date Stop	Total Doses	Date	Initials	Dose (mg)	Freq.	Date Start	Date Stop	Total Doses	Date	Initials
Rifampin														
Isoniazid														
Pyrazinamide														
Ethambutol														

14. FOLLOW-UP CHEST X-RAY

Note: If AFB cultures are all negative, obtain a CXR after two months of TB treatment and compare it to the original CXR. If CXR improved with TB treatment, then this is considered culture-negative (abacillary) active TB. For all TB patients, obtain a CXR at completion of TB treatment.

			Staff Initials	Date
Date of CXR: __/__/__	**Result:** ______________________________	**Improved compared to prior CXR?** ☐Y ☐N	____	__/__/__
Date of CXR: __/__/__	**Result:** ______________________________	**Improved compared to prior CXR?** ☐Y ☐N	____	__/__/__

15. RELEASE PLANNING

Projected Release Date: __/__/____ ☐ **"Unknown"**

Fill in Section 15 if the Projected Release Date is prior to the date of anticipated treatment completion, or if SENTRY indicates "unknown."

Upon release it is anticipated that the inmate will be:

☐**Deported to** (*specify country*)**:** _____

☐**Released in United States** (*specify U.S. address*)**:**

_____

_____

U.S. Contact person: _____

Relationship: _____ Phone: _____

Referral:

This entire TB Case/Suspect Report and Referral Form can be used as a referral form and faxed to the referral agency.

A referral should be made as soon as the case is identified: to the appropriate referral agency (CURE-TB or TBNet if being deported) or the State TB Control Program (see below).

If the inmate is to be deported, arrangements should be made for CURE-TB or TBNet to interview the inmate over the telephone (after the case is out of isolation) to obtain key locating information so that TB treatment can be continued in the country of origin.

Date referred: __/__/___

☐**State TB Control Program*:** _____
For State TB Control program contacts : http://tbcontrollers.org/?p=10

☐ **CURE-TB*** (Mexico referrals only)**:**
Phone: (619) 542-4013 *Fax:* (619) 692-8020

☐**TBNet *** (transnational referrals other than to Mexico)**:**
Phone: (512) 327-2017 *Fax:* (512) 327-6140

* No release of information form is needed for state TB programs or CURE-TB referrals.

Updated: ___/___/____ Initials: _____

16. TREATMENT COMPLETION

Date therapy stopped: __/__/____

Reason stopped:

☐Completed TB treatment (___ months of treatment)
☐Released
☐Transferred to: _____
☐Uncooperative or refused
☐Adverse treatment event
☐TB ruled out
☐Died
☐Other: _____
☐Unknown

If TB treatment extended >12 months, check reason(s):

☐Rifampin resistance ☐Nonadherence ☐Treatment failure
☐Adverse treatment event ☐Clinically indicated for other reasons
☐Other (*specify*): _____

Updated: ___/___/____ Initials: _____

17. FINAL CASE DETERMINATION

☐**Verified case of active TB:**

☐**Laboratory confirmed:**
☐Positive culture-MTB Complex
☐Positive NAAT (rapid test) - MTB Complex
☐Positive AFB smear (culture cannot be obtained)

☐**Meets clinical TB case criteria: Positive TST or IGRA** and CXR improvement after 2 months of TB treatment

☐**Provider diagnosis of TB**

TB Disease Site(s): ☐Pulmonary ☐Other: _____

☐**TB ruled out** (*explain*)**:** _____

☐**Unable to classify** (inmate released before work-up complete)

Updated: ___/___/____ Initials: _____

18. OTHER PERTINENT INFORMATION (compliance issues, side effects, etc.) *Indicate date when updated.*

_____
_____
_____
_____
_____
_____
_____
_____

STAFF INITIALS	STAFF NAME