U.S. Department of State

TUBERCULOSIS WORKSHEET

OMB No. 1405-0113
EXPIRATION DATE: xx/xx/20xx
ESTIMATED BURDEN: 15 MINUTES
(See Page 2 - Back of Form)

Photo	Surnames	Given Names	Age
	Birth Date *(mm-dd-yyyy)*	Document Type	Document Number	Case or Alien Number

1. Test for Cell-Mediated Immunity to Tuberculosis
See Tuberculosis Technical Instructions, when required, perform one type only, and attach results

IGRA performed, mark which test:	☐ QuantiFERON	☐ T-Spot TB	☐ Other (Indicate test name): _____
Date drawn (*mm-dd-yyyy*) _____ ☐ Positive ☐ Negative ☐ Indeterminate or Borderline	QuantiFERON (*indicate optimal density value [IU/ml] for each*) Nil Control: _____ TB Antigen1: _____ TB Antigen2: _____ Mitogen: _____	T-Spot (*indicate spot count for each*) Nil Control: _____ Panel A: _____ Panel B: _____ Positive Control: _____	Other IGRA (indicate optimal density value for each) Nil Control: _____ TB Antigen: _____ Mitogen _____

2. Chest X-Ray Indication *(Mark all that apply)*

☐ Chest X-Ray not indicated
☐ Age ≥ 15 years
☐ Signs or symptoms of tuberculosis
☐ Known HIV infection
☐ Extrapulmonary tuberculosis
☐ IGRA positive
☐ History of Tuberculosis
☐ TB Contact < 5 years

_____ Date Chest X-Ray Taken

3. Chest X-Ray Findings (for radiologist to complete all of Section 3)

☐ Normal Findings ☐ Abnormal Findings *(Indicate category and finding, marking all that apply in the tables below)*

Suggests Tuberculosis (Need Smears and Cultures)

☐ Infiltrate or consolidation
☐ Reticular markings suggestive of fibrosis
☐ Cavitary lesion
☐ Nodule(s) or mass with poorly defined margins *(such as tuberculoma)*
☐ Pleural effusion
☐ Hilar/mediastinal adenopathy
☐ Miliary findings
☐ Discrete linear opacity
☐ Discrete nodule(s) without calcification
☐ Volume loss or retraction
☐ Irregular thick pleural reaction
☐ Other

Does Not Need Smears and Cultures

Mark as Class B Other on DS-2054

☐ Cardiac
☐ Musculoskeletal
☐ Other, specify in Remarks

Do Not Mark as Class B Other on DS-2054

☐ Smooth pleural thickening (if at CPA, must confirm is not effusion [do lateral or decubitus radiograph or ultrasound])
☐ Diaphragmatic tenting
☐ Single or scattered calcified pulmonary nodule(s)
☐ Calcified lymph node(s)

Radiologist's Remarks

_____

_____

_____ Radiologist's Name *(Printed)*
_____ Radiologist's Signature *(Required)*
_____ Date Interpreted *(mm-dd-yyyy)*

4. Sputum Evaluation Decisions

☐ No, not indicated -Applicant has no signs or symptoms of TB, no known HIV infection, and:
- ☐ X-ray Normal or 'No specimens required' and test for cell-mediated immunity to TB negative *(if performed)*
- ☐ X-ray Normal or 'No specimens required' and test for cell-mediated immunity to TB positive *(if performed)*

☐ Yes, are indicated - Applicant has *(Mark all that apply):*
- ☐ Signs or symptoms of TB
- ☐ Chest X-ray suggests TB
- ☐ Known HIV Infection
- ☐ Extrapulmonary TB
- ☐ End of treatment cultures

5. AFB Smears, Cultures, and Molecular Testing Results

Select only one specimen type:

☐ Sputum

Exam requirements: 3 specimens for smear and culture plus molecular testing of the first specimen
End of treatment monitoring: 2 specimens for smear and culture

☐ Bronchial Lavage Fluid

Exam requirements: 2 specimens for smear and culture plus molecular testing of both specimens

☐ Gastric Aspirate

Exam requirements: 3 specimens for smear and culture plus molecular testing of the first specimen

	Date specimen obtained *(mm-dd-yyyy)*	Date smear result reported *(mm-dd-yyyy)*	Positive	Negative
AFB Smear Results				

	Date specimen obtained *(mm-dd-yyyy)*	Date culture reported *(mm-dd-yyyy)* **Use most recent date as date of exam on DS-2054*	Positive	Negative	NTM	Contaminated
Culture Results						

Molecular Test Type (Select One):

☐ GeneXpert MTB/RIF Ultra ☐ Cobas MTB/RIF ☐ HAIN Line Probe Assay (LPA) ☐ Genotype MTBDRplus

☐ Other (specify): _____

Date specimen obtained *(mm-dd-yyyy)*	Date of final result *(mm-dd-yyyy)*	*Mycobacterium* tuberculosis		Rifampin Resistance			Isoniazid Resistance		
		Detected	Not Detected	Detected	Not Detected	Indeterminate	Detected	Not Detected	Indeterminate

☐ Stool

Exam requirements: 3 consecutively collected stool samples for molecular testing only. If positive, gastric aspirates must be completed and documented above.

Molecular Test Type:

☐ GeneXpert MTB/RIF Ultra ☐ Other (specify): _____

Date specimen obtained *(mm-dd-yyyy)*	Date result *reported* *(mm-dd-yyyy)*	*Mycobacterium* tuberculosis		Rifampin Resistance			Isoniazid Resistance		
		Detected	Not Detected	Detected	Not Detected	Indeterminate	Detected	Not Detected	Indeterminate

6. Tuberculosis Classification

Applicants can be both Class B1 and Class B3, or Class B2 and Class B3. However, other combinations of tuberculosis classifications are not permitted.

☐ **No TB Classification**

☐ **Class A**
Applicant has infectious tuberculosis disease.

☐ **Class B0, TB, Pulmonary**
Diagnosed with tuberculosis by the panel physician or presented to the panel physician while on tuberculosis treatment and successfully completed DGMH-defined DOT.

☐ **Class B1 TB, Pulmonary**
Applicant required sputum collection but had negative cultures and was not diagnosed with infectious tuberculosis disease. This classification also includes applicants who were diagnosed with infectious tuberculosis disease by the panel physician, refused DGHM-defined DOT treatment, and are returning after treatment and completion of a minimum 1-year wait.

☐ **Class B1 TB, Extrapulmonary**
Applicants with evidence of extrapulmonary tuberculosis. The anatomic site of infection should be documented.

Anatomic Site of Disease _____

- ☐ No treatment
- ☐ Current treatment
- ☐ Completed treatment
- ☐ Started but did not finish extrapulmonary treatment

☐ **Class B2 TB, LTBI Evaluation**
Applicants who have a tuberculin skin test >10 mm or positive IGRA but otherwise have a negative evaluation for tuberculosis. Contacts with TST > 5 mm or positive IGRA should receive this classification (if they are not already Class B1 TB, Pulmonary).

- ☐ No LTBI treatment
- ☐ Current LTBI treatment
- ☐ Completed LTBI treatment
- ☐ Started but did not finish LTBI treatment

If treated, LTBI treatment:
- ☐ LTBI treatment by panel physician
- ☐ LTBI treatment by non-panel physician

Dates of treatment _____ to _____

If treated, mark LTBI regimen:
- ☐ Isoniazid
- ☐ Rifampin
- ☐ 3HP
- ☐ Other _____

☐ **Class B3 TB, Contact Evaluation**
Applicants who are a recent contact of a known tuberculosis case.

- ☐ No preventive treatment
- ☐ Window Prophylaxis
  - ☐ Isoniazid ☐ Rifampin ☐ 3HP ☐ Other _____ Dates of treatment _____ to _____

Source Case:

Name _____

Case or Alien Number, if known _____

Relationship to Contact _____

Date Contact Ended *(mm-dd-yyyy)* _____

Type of Source Case TB *(Mark only one and attach DST results)*
- ☐ Pansusceptible TB
- ☐ MDR TB (resistant to at least INH and rifampin)
- ☐ Drug-resistant TB other than MDR TB
- ☐ Culture negative
- ☐ Culture results not available
- ☐ DST results not yet available

Remarks

7. History of Class A TB

Complete this section only if one of the following is true *(mark appropriate option):*

☐ Applicant was previously diagnosed with Class A TB by the panel physician

☐ Applicant was on tuberculosis treatment at the time of presentation for their medical examination

How was the diagnosis made: ☐ Positive laboratory tests ☐ Clinical diagnosis

Diagnostic Chest Radiograph

Facility performing chest radiograph: _____

Date Radiograph obtained *(mm-dd-yyyy):* _____

Findings Present

☐ Normal or no findings suggestive of tuberculosis
☐ Infiltrate or consolidation
☐ Reticular marking suggestive of fibrosis
☐ Cavitary lesion
☐ Nodule(s) or mass with poorly defined margins (such as tuberculoma)
☐ Pleural effusion
☐ Hilar/mediastinal adenopathy
☐ Miliary findings
☐ Discrete linear opacity
☐ Discrete nodule(s) without calcification
☐ Volume loss or retraction
☐ Irregular thick pleural reaction
☐ Other

A. Specimen type and results (select one): ☐ Sputum ☐ Bronchial Lavage Fluid ☐ Gastric Aspirate

AFB Smear Result at Diagnosis

Date specimen obtained *(mm-dd-yyyy)*	Date results reported *(mm-dd-yyyy)*	Positive	Negative

Culture Result at Diagnosis

Date specimen obtained *(mm-dd-yyyy)*	Date results reported *(mm-dd-yyyy)*	Positive	Negative	NTM	Contaminated

Molecular Testing Result at Diagnosis

Molecular Test Type (Select One):

☐ GeneXpert MTB/RIF Ultra ☐ Cobas MTB/RIF ☐ HAIN Line Probe Assay (LPA) ☐ Genotype MTBDRplus

☐ Other (specify): _____

Date specimen obtained *(mm-dd-yyyy)*	Date of final result *(mm-dd-yyyy)*	*Mycobacterium* tuberculosis		Rifampin Resistance			Isoniazid Resistance		
		Detected	Not Detected	Detected	Not Detected	Indeterminate	Detected	Not Detected	Indeterminate

☐ Stool

Molecular Test Type:

☐ GeneXpert MTB/RIF Ultra ☐ Other (specify): _____

Date specimen obtained *(mm-dd-yyyy)*	Date result *reported* *(mm-dd-yyyy)*	*Mycobacterium* tuberculosis		Rifampin Resistance			Isoniazid Resistance		
		Detected	Not Detected	Detected	Not Detected	Indeterminate	Detected	Not Detected	Indeterminate

7. History of Class A TB

B. Drug Susceptibility Test Results

Culture-based (phenotypic) DST	Date specimen obtained *(mm-dd-yyyy)*	Date DST reported *(mm-dd-yyyy)*
☐ MGIT ☐ Agar ☐ LJ		

Required for:	Drug	Susceptible	Resistant
First-line DST	Isoniazid		
	Rifampin		
	Ethambutol		
	Pyrazinamide		
If Fluoroquinolone used:	Fluoroquinolone, specify: _____		
Second-line DST for multidrug-resistant cases	Ethionamide		
	Amikacin		
	Capreomycin		
	Other, specify: _____		
	Other, specify: _____		
	Other, specify: _____		
	Other, specify: _____		

Molecular DST (Optional, Does not replace cultural-based DST)	Date specimen obtained *(mm-dd-yyyy)*	Date DST reported *(mm-dd-yyyy)*
☐ Xpert XDR ☐ GenoType MTBDRsl ☐ Other, specify: _____		

Drug		Drug		
		Detected or Inferred	Not Detected or Not Inferred	Indeterminate
Drugs tested	Isoniazid			
	Fluoroquinolone			
	Amikacin			
	Kanamycin			
	Capreomycin			
	Ethionamide			
Other, specify:				
Other, specify:				
Other, specify:				

Tuberculosis Treatment

Treating physician or institution

☐ Approved DOT site: _____

☐ Unapproved TB treatment site: _____

Drug	Dosage	Start Date *(mm-dd-yyyy)*	End Date *(mm-dd-yyyy)*
Isoniazid			
Rifampin			
Ethambutol			
Pyrazinamide			
Other, specify:			

PAPERWORK REDUCTION ACT AND CONFIDENTIALITY STATEMENTS

PAPERWORK REDUCTION ACT STATEMENT

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