

CASE REPORT FORM

Tuberculosis

		EpiSurv No. <input type="text"/>	
Disease Name ?			
<input type="radio"/> Tuberculosis disease - new case		<input type="radio"/> Tuberculosis disease - relapse or reactivation	
<input type="radio"/> Latent tuberculosis infection (patient consent required)		<input type="radio"/> Tuberculosis infection - old disease on preventive treatment (fully investigated and active disease excluded)	
Reporting Authority			
Name of Public Health Officer responsible for case		<input type="text" value="OfficerName"/>	
Notifier Identification i			
Reporting source* Report Src <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		Organisation <input type="text" value="ReportOrganisation"/>	
Date reported* <input type="text" value="ReportDate"/>		Laboratory sample date <input type="text" value="SampleDate"/>	Contact phone <input type="text" value="ReportPhone"/>
Usual GP <input type="text" value="UsualGP"/>	Practice <input type="text" value="GPPracticeName"/>		GP phone <input type="text" value="GPPhone"/>
GP/Practice address		Number <input type="text" value="houzenumber"/> Street <input type="text" value="streetname"/> Suburb <input type="text" value="suburb"/>	
GpAddress		Town/City <input type="text" value="towncity"/>	Post Code <input type="text" value="postcode"/> <input type="checkbox"/> GeoCode <input type="text"/>
Case Identification i			
Name of case* Surname <input type="text" value="Surname"/>		Given Name(s) <input type="text" value="GivenName"/>	
NHI number* <input type="text" value="NHINumber"/>		Email <input type="text" value="Email"/>	
Current address* Number <input type="text"/>		Street <input type="text"/> Suburb <input type="text"/>	
CaseAddress		Town/City <input type="text"/>	Post Code <input type="text"/> <input type="checkbox"/> GeoCode <input type="text"/>
Phone (home) <input type="text" value="PhoneHome"/>	Phone (work) <input type="text" value="PhoneWork"/>	Phone (other) <input type="text" value="PhoneOther"/>	
Case Demography			
Location TA* <input type="text" value="TA"/>		DHB* <input type="text" value="DHB"/>	
Date of birth* <input type="text" value="DateOfBirth"/>		OR Age <input type="text" value="Age"/> AgeUnits <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years	
Sex* Sex <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown <input type="radio"/> Other			
Occupation* <input type="text" value="Occupation"/>		i	
Occupation location Occupation_place_type - main		<input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school	
Name <input type="text" value="occupation_place_name - main"/>			
Address		Number <input type="text"/> Street <input type="text"/> Suburb <input type="text"/>	
PlaceOfWork - Main		Town/City <input type="text"/> Post Code <input type="text"/> <input type="checkbox"/> GeoCode <input type="text"/>	
Alternative location Occupation_place_type - Alternative		<input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school	
Name <input type="text" value="occupation_place_name - Alternative"/>			
Address		Number <input type="text"/> Street <input type="text"/> Suburb <input type="text"/>	
PlaceOfWork - Alternative		Town/City <input type="text"/> Post Code <input type="text"/> <input type="checkbox"/> GeoCode <input type="text"/>	
Ethnic group case belongs to* (tick all that apply) i			
<input type="checkbox"/> NZ European EthNZEuropan <input type="checkbox"/> Maori EthMaori <input type="checkbox"/> Samoan EthSamoan <input type="checkbox"/> Cook Island Maori EthCookIslandMaori			
<input type="checkbox"/> Niuean EthNiuean <input type="checkbox"/> Chinese EthChinese <input type="checkbox"/> Indian EthIndian <input type="checkbox"/> Tongan EthTongan			
<input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan) EthOther *(specify) <input type="text" value="EthSpecify1"/> <input type="text" value="EthSpecify2"/>			

Tuberculosis	EpiSurv No. <input style="width: 80%;" type="text"/>
Basis of Diagnosis	
LABORATORY CRITERIA i	
Meets laboratory criteria for disease* LabConf	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Demonstration of acid-fast bacilli in a clinical specimen AcidFast	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results
If yes, specify site AcidFSite	<input type="radio"/> Sputum <input type="radio"/> Other (specify) AcidFSiteSpec <input style="width: 100px;" type="text"/>
Isolation of <i>Mycobacterium tuberculosis</i> complex from a clinical specimen Isolation	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results
If yes, specify site IsoSite	<input type="radio"/> Sputum <input type="radio"/> Other (specify) IsoSiteSpec <input style="width: 100px;" type="text"/>
Demonstration of <i>Mycobacterium tuberculosis</i> complex nucleic acid PCR	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results
If yes, specify site PCRSite	<input type="radio"/> Sputum <input type="radio"/> Other (specify) PCRSiteSpec <input style="width: 100px;" type="text"/>
Histology strongly suggestive of tuberculosis Histology	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results
MANTOUX STATUS	
Mantoux tests done* ManTest	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Awaiting Results <input type="radio"/> Unknown
Date* <input style="width: 100px;" type="text"/> mm induration* <input style="width: 50px;" type="text"/> mm ManDate1 Manmm1	Date* <input style="width: 100px;" type="text"/> mm induration* <input style="width: 50px;" type="text"/> mm ManDate2 Manmm2
Mantoux status* (tick most appropriate - must use definitions in TB guidelines) ManStatus	
<input type="radio"/> Mantoux Negative <input type="radio"/> Mantoux Positive <input type="radio"/> Mantoux Converted <input type="radio"/> Mantoux Unknown	
IGRA STATUS	
Test done* IGRATestDone <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Awaiting Results <input type="radio"/> Unknown	
If yes, result IGRATestResult <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Indeterminate	
OTHER CRITERIA	
Treatment for presumptive TB* TmtPresumptive <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Interim treatment for presumptive LTBI in children < 5 years* TmtPresLTBI <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
STATUS* <input type="radio"/> Under investigation <input type="radio"/> Probable - presumptive <input type="radio"/> Confirmed <input type="radio"/> Not a case i	
Status (no laboratory confirmation) (laboratory confirmation)	
PREVIOUS HISTORY OF TUBERCULOSIS (relapses or reactivations only)	
Date of first tuberculosis diagnosis* <input style="width: 150px;" type="text"/> DateFirstTB	Name of doctor* <input style="width: 150px;" type="text"/> DrTBDig
Place where diagnosis made (town/city/country)* PlaceTBDig <input style="width: 250px;" type="text"/>	
Was diagnosis confirmed by laboratory testing?* TBDigLab <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Was the case treated?* CaseTreat <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
If yes, duration of treatment* DurTreat <input style="width: 100px;" type="text"/> months	
ADDITIONAL CLINICAL DETAILS	
Site of disease (disease only)	
Pulmonary* Pulmon <input type="radio"/> Yes <input type="radio"/> No	
If yes,	
Radiology* Radiology <input type="radio"/> Normal <input type="radio"/> Active TB <input type="radio"/> TB of Uncertain Activity <input type="radio"/> Not Done <input type="radio"/> Unknown	
Evidence of cavity formation* EvidOfCavity <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	

Tuberculosis	EpiSurv No. <input style="width: 80%;" type="text"/>
Basis of Diagnosis (continued)	
Extrapulmonary* Extrapulm <input type="radio"/> Yes <input type="radio"/> No	
If yes, tick all that apply*	
<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Lymph node (excl abdomen) LymphNode </div> <div> <input type="checkbox"/> Pleural Pleural </div> <div> <input type="checkbox"/> MiliaryTB MiliaryTB </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div> <input type="checkbox"/> Bone/joint BoneJoint </div> <div> <input type="checkbox"/> Intraabdominal (excl renal) Intraabdominal </div> <div> <input type="checkbox"/> Renal/genitourinary tract RenalUrinaryTract </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div> <input type="checkbox"/> Soft tissue/skin SoftSkinTissue </div> <div> <input type="checkbox"/> CNS TB (including meningitis) CNSTB </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div> <input type="checkbox"/> Other site, specify OtherExtraPulmonarySiteSpe </div> <div style="border: 1px solid black; width: 350px; height: 20px;"></div> </div>	
How was case/infection discovered?* HowDisc	
<div style="display: flex; justify-content: space-between;"> <div> <input type="radio"/> Contact follow-up </div> <div> <input type="radio"/> Immigrant/refugee screening </div> <div> <input type="radio"/> Attended practitioner with symptoms </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div> <input type="radio"/> Other (specify) HowDiscSpec <div style="border: 1px solid black; width: 150px; height: 20px;"></div> </div> <div> <input type="radio"/> Unknown </div> </div>	
ADDITIONAL LABORATORY DETAILS (CULTURE POSITIVE CASES ONLY and PHF SCIENCE UPDATED)	
Mycobacterial species OrganIsol <input type="radio"/> <i>Mycobacterium tuberculosis</i> <input type="radio"/> <i>Mycobacterium bovis</i> <input type="radio"/> Other (*specify) OrganIsolSpec <div style="border: 1px solid black; width: 250px; height: 20px;"></div>	
Susceptibility testing results	
Isoniazid (0.1 mg/L) IsoniazidLow	<input type="radio"/> Susceptible <input type="radio"/> Resistant
Isoniazid (0.4 mg/L) IsoniazidHigh	<input type="radio"/> Susceptible <input type="radio"/> Resistant
Rifampicin Rifampicin	<input type="radio"/> Susceptible <input type="radio"/> Resistant
Ethambutol Ethambutol	<input type="radio"/> Susceptible <input type="radio"/> Resistant
Pyrazinamide Pyrazinamide	<input type="radio"/> Susceptible <input type="radio"/> Resistant
Moxifloxacin Moxifloxacin	<input type="radio"/> Susceptible <input type="radio"/> Resistant
<i>Other antibiotics (specify)</i>	
Antibiotic1 <div style="border: 1px solid black; width: 150px; height: 20px;"></div>	<input type="radio"/> Susceptible <input type="radio"/> Resistant
Antibiotic2 <div style="border: 1px solid black; width: 150px; height: 20px;"></div>	<input type="radio"/> Susceptible <input type="radio"/> Resistant
Antibiotic3 <div style="border: 1px solid black; width: 150px; height: 20px;"></div>	<input type="radio"/> Susceptible <input type="radio"/> Resistant
Antibiotic4 <div style="border: 1px solid black; width: 150px; height: 20px;"></div>	<input type="radio"/> Susceptible <input type="radio"/> Resistant
Antibiotic5 <div style="border: 1px solid black; width: 150px; height: 20px;"></div>	<input type="radio"/> Susceptible <input type="radio"/> Resistant
Antibiotic6 <div style="border: 1px solid black; width: 150px; height: 20px;"></div>	<input type="radio"/> Susceptible <input type="radio"/> Resistant
Antibiotic7 <div style="border: 1px solid black; width: 150px; height: 20px;"></div>	<input type="radio"/> Susceptible <input type="radio"/> Resistant
Specimen details Date specimen taken SusDateSpecimenTaken <div style="border: 1px solid black; width: 100px; height: 20px;"></div> Specimen number SusSpecimenNumber <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	
SusAutoUpdated <input type="checkbox"/> Reference laboratory SusReferenceLaboartory <div style="border: 1px solid black; width: 100px; height: 20px;"></div> Date results updated SusDateUpdated <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	
Molecular Typing	
MIRU MIRU <div style="border: 1px solid black; width: 150px; height: 20px;"></div>	RFLP RFLP <div style="border: 1px solid black; width: 150px; height: 20px;"></div> ClusterID ClusterID <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
WGS WGS <input type="checkbox"/> Lineage Lineage <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	Sublineage Sublineage <div style="border: 1px solid black; width: 100px; height: 20px;"></div> WGS Cluster ID WGSClusterID <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
Updated TypingAutoUpdated <input type="checkbox"/> Date Results Updated TypingDateUpdated <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	Specimen Number TypingSpecimenNumber <div style="border: 1px solid black; width: 100px; height: 20px;"></div>

Tuberculosis	EpiSurv No. <input style="width: 80%;" type="text"/>
Clinical Course and Outcome	
Date of onset* OnsetDt <input style="width: 150px;" type="text"/>	<input type="checkbox"/> Approximate OnsetDtApprox <input type="checkbox"/> Unknown OnsetDtUnknown <input type="checkbox"/> Asymptomatic Asymptomatic
Hospitalised* Hosp <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Date hospitalised* HospDt <input style="width: 150px;" type="text"/>	<input type="checkbox"/> Unknown HospDtUnknown
Hospital* HospName <input style="width: 350px;" type="text"/>	
Died* Died <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Date died* DiedDt <input style="width: 150px;" type="text"/>	<input type="checkbox"/> Unknown DiedDtUnknown
Was this disease the primary cause of death?* DiedPrimary <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
If no, specify the primary cause of death* DiedOther <input style="width: 350px;" type="text"/>	
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)?*	
<input type="checkbox"/> Yes Outbrk If yes, specify Outbreak No* OutbrkNo <input style="width: 150px;" type="text"/>	
Risk Factors	
Has HIV test been performed* HIVTest	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Other immunosuppressive illness (chronic renal failure, alcoholism, diabetes, gastrectomy)* Immunoll	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
If yes, specify ImmunollSpecify <input style="width: 350px;" type="text"/>	
Immunosuppressive medication* ImmunoMed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Contact with a confirmed case of tuberculosis* ContCase	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
If yes, specify nature of contact* ContSpec <input style="width: 350px;" type="text"/>	
If yes, did contact occur within New Zealand* ContNZ	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
If yes, specify name of case* ContNZName <input style="width: 350px;" type="text"/>	
Born outside New Zealand* BornOutNZ	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
If yes, specify country of birth* BrCountry <input style="width: 350px;" type="text"/>	
If yes, date of arrival in NZ* ArrivDate <input style="width: 150px;" type="text"/> <input type="checkbox"/> Unknown ArrivDateUnknown	
Current or recent residence in a household with a person (s) born outside New Zealand* CurrResid	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
If yes, specify country of birth* OthCountry <input style="width: 350px;" type="text"/>	
Exposure in health care setting* ExpHlth	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
If yes, specify exposure* ExpHlthSpec <input style="width: 350px;" type="text"/>	
Current or recent residence in an institution (e.g. prison)* Instute	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
If yes, specify details* InstuteSpec <input style="width: 350px;" type="text"/>	
Exposure to cattle, deer, possums, other wild animals or animal products in work or recreation* ExpCattle	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
*If yes, specify exposure in detail CattleSpec <input style="width: 350px;" type="text"/>	
Other risk factors for tuberculosis* RiskOthSpecify	
(specify*) <input style="width: 650px; height: 50px;" type="text"/>	

Tuberculosis	EpiSurv No. <input style="width: 80%;" type="text"/>
Protective Factors	
At any time prior to onset, had the case been immunised with BCG vaccine?* BCGVacc <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
If yes, specify date given* BCGDate <input style="width: 150px;" type="text"/> <input type="checkbox"/> Unknown BCGDateUnknown	
If yes, how was this confirmed* BCGConf <input type="radio"/> Scar <input type="radio"/> Patient/Caregiver recall <input type="radio"/> Documented <input type="radio"/> Unknown	
Management	
CASE MANAGEMENT	
Under specialist care* SpecIstCare <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Name of specialist* SpecIstName <input style="width: 400px;" type="text"/>	
Did the case receive treatment?* <input type="radio"/> Yes <input type="radio"/> Treatment declined <input type="radio"/> Treatment inappropriate <input type="radio"/> Unknown	
ReceivedTreat If yes	
Date treatment started* StDateTmt <input style="width: 150px;" type="text"/> <input type="checkbox"/> Unknown StDateTmtUnknown	
Date treatment ended in NZ* EndDateNZTmt <input style="width: 150px;" type="text"/> <input type="checkbox"/> Unknown EndDateNZTmtUnknown	
Was treatment interrupted?* TmtInterrupted <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Reason treatment ended* ReasonTmtEnded 	
<div style="display: flex; justify-content: space-between;"> <div> <input type="radio"/> Tmt completed to the satisfaction of the prescribing doctor <input type="radio"/> Went overseas (medical care not transferred or unknown) <input type="radio"/> Refused to complete treatment <input type="radio"/> Stopped due to pregnancy <input type="radio"/> Discontinuation of interim treatment for LTBI (child <5 years) </div> <div> <input type="radio"/> Transferred to overseas medical care <input type="radio"/> Died <input type="radio"/> Stopped treatment because of adverse effects <input type="radio"/> Lost to follow up <input type="radio"/> Reason unknown </div> </div>	
Did case receive DOT throughout the intensive phase of treatment?* <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
DOTThrOutIntensive	
Did case receive DOT throughout the course of treatment?* DOTThrOut <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
CONTACT MANAGEMENT (disease only)	
Did case have any contacts at risk of infection?* RiskInfect <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown 	
If yes, type of contact: Number Identified	
Close contacts* CloseCont	<input style="width: 100px;" type="text"/>
Casual contacts* CasualCont	<input style="width: 100px;" type="text"/>
Comments*	
Comments <div style="border: 1px solid black; height: 150px; margin-top: 5px;"></div>	