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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Notification Details** | | General Practitioner | | | | | | | Hospital Practitioner | | | | | | Other | | | | | | | | |
| **Name of person notifying** | |  | | | | | | | **Date reported** | | | | | |  | | | | | | | | |
| **Notifier Organisation** | |  | | | | | | | **Phone** | | | | | |  | | | | | | | | |
| **Usual GP: Name and Practice** | |  | | | | | | | **Phone** | | | | | |  | | | | | | | | |
| **disease Name** | | Tuberculosis disease – new case | | | Latent tuberculosis infection | | | | Tuberculosis disease – relapse or reactivation | | | | | | | | | | Tuberculosis infection – old disease on preventive treatment | | | | |
| **TuberCULOSIS PATIENT Details** | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of patient** | | **Surname** | | | | | | | | **First name(s)** | | | | | | | | | | | | | |
| **NHI Number** | |  | | **Date of birth** | | | | | **Click for date** | | | | | | **Gender** | | | | |  | | | |
| **Address** | |  | | | | | | | | | | | | | | | | | | | | | |
| **Phone Home** | |  | | **Phone Work** | | | | |  | | | | | | **Mobile** | | | | |  | | | |
| **Ethnicity** | | **Choose an item** | | | | | | | **Other, please specify** | | | | | | | | | | | | | | |
| **Occupation and employer** | |  | | | | | | | | | | | | | | | | | | | | | |
| **Attends/works at ELS, School, Healthcare facility, or Residential facility** | | Yes  No | | **If yes, name & address of facility:** | | | | | | | | | | | | | | | | | | | |
| **BASIS OF DIAGNOSIS** | | | | | | | | | | | | | | | | | | | | | | | |
| **Laboratory confirmation of disease** | | Yes | | | No | | | | Unknown | | | | | | |  | | | | | | | |
| **Demonstration of acid-fast bacilli in a clinical specimen** | | Yes  If yes, specify site  Sputum  Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | No | | | | Not Done | | | | | | | Awaiting Results | | | | | | | |
| **Isolation of Mycobacterium tuberculosis, or M.bovis from a clinical specimen** | | Yes  If yes, specify site  Sputum  Other (specify)  ­­­ | | | No | | | | Not Done | | | | | | | Awaiting Results | | | | | | | |
| **Demonstration of M.tuberculosis nucleic acid (PCR or LCR only)** | | Yes  If yes, specify site  Sputum  Other (specify) \_\_\_\_\_\_\_\_\_\_ | | | No | | | | Not Done | | | | | | | Awaiting Results | | | | | | | |
| **Histology strongly suggestive of tuberculosis** | | Yes | | | No | | | | Not Done | | | | | | | Awaiting Results | | | | | | | |
| **Are there any results suggesting drug resistant M. tuberculosis?** | Yes  If yes, specify: | | | | | | | | | | | | | | | No | | | | | | | |
| **STATUS** | | Under Investigation | | | Probable – presumptive (no laboratory confirmation) | | | | | | | | | Confirmed (laboratory confirmation) | | | | | | | | Not a case | |
| **OTHER CRITERIA** | | | | | | | | | | | | | | | | | | | | | | | |
| **Treatment for presumptive TB** | | Yes | | | No | | | | | | | | | | | | Unknown | | | | | | |
| **Pulmonary** | | | | Yes  No | | | | | **If yes, Radiology**  Normal  Active TB  TB of uncertain activity  Not Done  Unknown | | | | | | **If yes, Evidence of cavity formation**  Yes  No  Unknown | | | | | | | | |
| **Extrapulmonary** | | | | Yes  No | | | | | **If yes, tick all that apply**  Lymph node (excl abdomen)  Bone/ joint  Soft tissue/skin  Pleural  Intraabdominal (excl renal)  CNS TB (incl meningitis)  Miliary TB  Renal/ genitourinary tract  Other | | | | | | | | | | | | | | |
| **How was case/infection discovered?** | | | | Contact follow-up | | | | | Immigrant/ refugee screening | | | | | | Attended practitioner  with symptoms | | | | | | | | Other (specify)  ­­­­­­­\_\_\_\_\_\_\_\_\_ |
| **ADDITIONAL LABORATORY DETAILS (Culture positive cases only and ESR updated)** | | | | | | | | | | | | | | | | | | | | | | | |
| **Mycobacterial species** | | | Mycobacterium tuberculosis | | | M.bovis | | | | | | | | | Other (specify) ­­­­\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **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  (please attach any information) | | | | | No | | | | | | | | Unknown | | | | | | | |
| **Was patient treated? If yes, duration of treatment** | | | Yes \_\_\_\_\_ months | | | | | No | | | | | | | | Unknown | | | | | | | |
| **CLINICAL COURSE and OUTCOME** | | | | | | | | | | | | | | | | | | | | | | | |
| **Date of onset** | | | Date \_\_\_\_\_\_\_\_\_\_ | | | | Approximate | | | | | Unknown | | | | | | | | | Asymptomatic | | |
| **Hospitalised? If yes date of hospitalisation** | | | Yes Date \_\_\_\_\_\_\_\_\_\_\_ | | | | | | No | | | | | | | | | Unknown | | | | | |
| **Died? If yes, date of death** | | | Yes Date \_\_\_\_\_\_\_\_\_\_\_ | | | | | | No | | | | | | | | | Unknown | | | | | |
| **Was this disease the primary cause of death? If no, specify primary cause of death** | | | Yes | | | | | | No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | Unknown | | | | | |
| **RISK FACTORS** | | | | | | | | | | | | | | | | | | | | | | | |
| **Has HIV test been performed** | | | Yes | | | | | | No | | | | | | | | | Unknown | | | | | |
| **Other immunosuppressive illness (chronic renal failure, alcoholism, diabetes, gastrectomy)** | | | Yes Specify \_\_\_\_\_\_\_\_\_ | | | | | | No | | | | | | | | | Unknown | | | | | |
| **Immunosupressive medication? If yes, specify** | | | Yes Specify \_\_\_\_\_\_\_\_\_ | | | | | | No | | | | | | | | | Unknown | | | | | |
| **Exposure in healthcare setting** | | | Yes Specify \_\_\_\_\_\_\_\_\_ | | | | | | No | | | | | | | | | Unknown | | | | | |
| **Current or recent residence in an institution (e.g. prison) If yes, specify** | | | Yes Specify \_\_\_\_\_\_\_\_\_ | | | | | | No | | | | | | | | | Unknown | | | | | |
| **Born outside New Zealand?** | | | Yes Specify country and date of arrival \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | No | | | | | | | | | Unknown | | | | | |
| **MANAGEMENT** | | | | | | | | | | | | | | | | | | | | | | | |
| **Under specialist care? If yes, specify name** | | | Yes Specify \_\_\_\_\_\_\_\_\_ | | | | | | No | | | | | | | | | Unknown | | | | | |
| **Did the patient receive treatment? If yes, date started** | | | Yes Date\_\_\_\_\_\_\_\_\_ | | | | | Treatment declined | | | | | Treatment inappropriate | | | | | | | | Unknown | | |
| **CONTACT MANAGEMENT** | | | | | | | | | | | | | | | | | | | | | | | |
| **Are there any high priority contacts identified (e.g. < 5yrs, pregnant, immune suppressed)** | | | Yes Specify \_\_\_\_\_\_\_\_\_ | | | | | | No | | | | | | | | | Unknown | | | | | |
| **COMMENTS** | | | | | | | | | | | | | | | | | | | | | | | |
| e.g. isolation, treatment or adherence risks, antimicrobial susceptibilities, source or contact tracing information, suspicion of an outbreak, suspicion of M.bovis. | | | | | | | | | | | | | | | | | | | | | | | |