Tuberculosis (TB) Incident Report

Complete this form to report any of the following events: media sensitive exposures, exposures with ≥ 50 contacts in a single site, child daycare or K-12 school exposures with ≥ 25 contacts, or any other exposures deemed concerning by the program. Please attach the form to the NEDSS investigation and send email notification to TBEpi@dshs.texas.gov within 48 hours of incident. Fields may be left blank if information is pending.

Incident Reports involving exposures in a correctional facility should be submitted using the form 12-12063.

A. Incident Report Information	
Submission Date:	Local Contact Person:
City of Incident:	Title:
County of Incident:	Phone Number:
Public Health Jurisdiction:	Email:
Location of Concerning Exposure:	

B. Suspected or Confirmed Case Information		
Patient Name:	TST Performed? □ Yes □ No □ Unknown	
DOB: NEDSS Investigation ID:	TST Date Placed:	TST Date Read:
Gender: □ Male □ Female □ Other:	Results (mm):	□ Positive □ Negative
Country of Birth:	IGRA Result: □ Positive □ Negative □ Pending □ Indeterminate/Borderline □ Not Performed	
If not U.S., Arrival Date:		
Symptom Onset Date:	IGRA Test Date:	
□ Cough □ Chills □ Hemoptysis □ Fever □ Fatigue □ Loss of appetite □ Night Sweats □ Weight Loss □ Other, please specify:	IGRA Test Type: □ T-SPOT □ QFT □ Unknown	
	AFB Specimen Site:	
	Collection Date:	
Symptom End Date:	Specimen sent to DSHS? □ Yes □ No □ Unknown	
Hospitalized? □ No □ Yes, Dates: _____ to _____	AFB Sputum Smear Result: □ Positive □ Negative □ Pending □ Not Performed	
Name of Hospital:		
Infectious? □ No □ Yes, Dates: _____ to _____	NAAT Result: □ Positive □ Negative □ Pending □ Not Performed	
If yes, isolated? □ Yes □ No		
Started on Treatment? □ Yes □ No □ Unknown	AFB Culture Result: □ Positive □ Negative □ Pending □ Not Performed	
Start Date: End Date:		
Started on RIPE? □ Yes □ No □ Unknown	Chest Imaging Performed? □ Yes □ No □ Unknown	
If not RIPE, specify regimen:	Chest Imaging Type:	
Case Died? □ No □ Yes, Date of Death:	Date:	Results: □ Normal □ Abnormal
Was TB diagnosed at death? □ Yes □ No □ Unknown	Cavitary? □ Yes □ No	Miliary? □ Yes □ No
Was TB cause of death? □ Yes □ No □ Unknown		
Comments:		

C. Exposure Location Information

Site Name: | **Site Location:**

Exposure Dates: | **Site Visit Performed**: □ Yes □ No | **Site Visit Date**:

Site Type: □ Child Daycare □ K-12 School □ College/University □ Homeless Shelter/Group Home
□ Nursing Home/Hospice □ Long-term Care Facility □ Assisted Living/Adult Daycare
□ Outpatient Medical Facility □ Hospital/Inpatient Medical Facility
□ Other, specify:

#High Priority:	#Medium Priority:	#Low Priority:	Total # Contacts:

Please describe site environment(s) (i.e. large vs. small room, ventilation details, etc.)

Site Name: | **Site Location:**

Exposure Dates: | **Site Visit Performed:** □ Yes □ No | **Site Visit Date:**

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□ Other, specify:

#High Priority:	#Medium Priority:	#Low Priority:	Total # Contacts:

Please describe site environment(s) (i.e. large vs. small room, ventilation details, etc.)

Investigation Activities

Provide a timeline for all screening activities (completed and anticipated). Include specific dates where possible.

Media Involvement

Has the media become involved with this incident? □ Yes □ No □ Possible

If yes, provide the name of media source and media contact person (if available) or all media involved: