TEXAS Health and Human Services

Texas Department of State Health Services

TEXAS HANSEN'S DISEASE PROGRAM
SURVEILLANCE FORM AND TEXAS CASE REPORT

Fill out all surveillance data and patient information, and send to the Texas Department of State Health Services (DSHS) within 1 week. Page 1 is the National Hansen's Disease (NHDP) Surveillance Form, pages 2-4 are required for Texas reporting, pages 5-6 are instructions. Contact DSHS at 737-255-4300 for questions regarding reporting HD in Texas.

ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL

HANSEN'S DISEASE *(LEPROSY)* SURVEILLANCE FORM

NATIONAL HANSEN'S DISEASE PROGRAMS
9181 INTERLINE AVENUE PARK DRIVE
BATON ROUGE, LA 70809
1-800-642-2477

FOR NHDP USE ONLY

1 Reporting State: ☐☐

2 Date of Report: Mo. ☐☐ Day ☐☐ Yr. ☐☐

3 Social Security Number *(optional)*: ☐☐☐-☐☐-☐☐☐☐

4 Patient Name: *(Last)* *(First)* *(Middle)*

5 Present Address: Street _____ City _____

County _____ State _____ Zip _____

6 Place of Birth:
State _____ City _____
Country _____

7 Date of Birth: Mo. ☐☐ Day ☐☐ Yr. ☐☐ **Sex:** ☐ Male ☐ Female

8 Race/Ethnicity: ☐ White, Not Hispanic ☐ White, Hispanic ☐ American Indian, Alaska Native ☐ Indian, Middle Easterner ☐ Black, Not Hispanic ☐ Black, Hispanic ☐ Asian ☐ Native Pacific Islander ☐ Not Specified

9 Date Entered U.S.: Mo. ☐☐ Yr. ☐☐

10 Date of Onset of Symptoms: Mo. ☐☐ Yr. ☐☐

11 Date Leprosy First Diagnosed: Mo. ☐☐ Yr. ☐☐

12 How many doctors have you seen for this problem? ☐

13 Initial Diagnosis: ☐ In U.S. ☐ Outside U.S.

14 Type of Leprosy: *(ICD-10-CM Code)* **(NHDP Clinic physicians: Please circle specific classification, if possible)**

- ☐ Lepromatous Leprosy *(A30.5 - LL)*
- ☐ Borderline Lepromatous *(A30.4 - BL)*
- ☐ Tuberculoid *(A30.1 - TT)*
- ☐ Borderline Tuberculoid *(A30.2 - BT)*
- ☐ Indeterminate *(A30.0 - IN)*
- ☐ Borderline *(A30.3 - BB)*
- ☐ Other Specified Leprosy *(A30.8)*
- ☐ Leprosy, Unspecified *(A30.9)*

15 Diagnosis of Disease:

Leprosy reaction at diagnosis? ☐ Yes ☐ No

Was biopsy performed in U.S.? ☐ Yes ☐ No

Date ☐☐ / ☐☐ / ☐☐

Result _____

Skin Smear? ☐ Yes ☐ No ☐☐/☐☐/☐☐ Date

BI: Positive ____ Negative ____

16 List all places in the U.S.A. and all foreign countries a PATIENT resided *(Including Military Service)* BEFORE leprosy was diagnosed:

TOWN	COUNTY	STATE	COUNTRY	INCLUSIVE DATES From Mo./Yr.	INCLUSIVE DATES To Mo./Yr.

17 Disability:

	Hands				Feet							
	Right		Left		Right		Left		Right		Left	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Loss of Sensation?	☐	☐	☐	☐	☐	☐	☐	☐				
Visible deformity?	☐	☐	☐	☐	☐	☐	☐	☐				
Blink abnormal?									☐	☐	☐	☐
Lagophthalmos?									☐	☐	☐	☐

18 Current Household Contacts: **Name/Relationship**

1 _____

2 _____

3 _____

4 _____

19 Current Treatment for Leprosy: *(check all that apply)*

Date Treatment Started: ☐☐ Mo. ☐☐ Yr.

☐ Dapsone ☐ Rifampin ☐ Clofazimine

Other *(list)* _____

20 Name and Address of Physician: _____

Investigator:

Once all pages are complete, please fax to 512-989-4010 to report new cases of Hansen's Disease.

Name (Last, First) _____ *DOB:* _____

21. Aliases:		22. Phone Number(s):	
23. Entered Texas Date: From Where:	24. Citizen of:	25. Education:	26. Employment:
27. Health Insurance: ☐ Medicare ☐ Medicaid ☐ BC/BS ☐ Private Insurance ☐ None			
28. Armadillo Contact? ☐ Yes ☐ No ☐ Unknown Describe:			
29. Date of Onset of Symptoms: ☐☐/☐☐/☐☐ Give Brief Description & History Prior to Diagnosis:			
30. Diagnosing Physician Information (indicate Yes or No if this is also the treating physician): Name: _____ Address: _____ City: _____ Phone: _____			
31. Known Contact with Hansen's Disease Case? ☐ Yes ☐ No ☐ Unknown			

(If answered Yes to #31) Name of Suspected Source	DOB	Sex	Relationship	Household Contact	Inclusive Dates of Contact

Name (Last, First): _____ *DOB:* _____

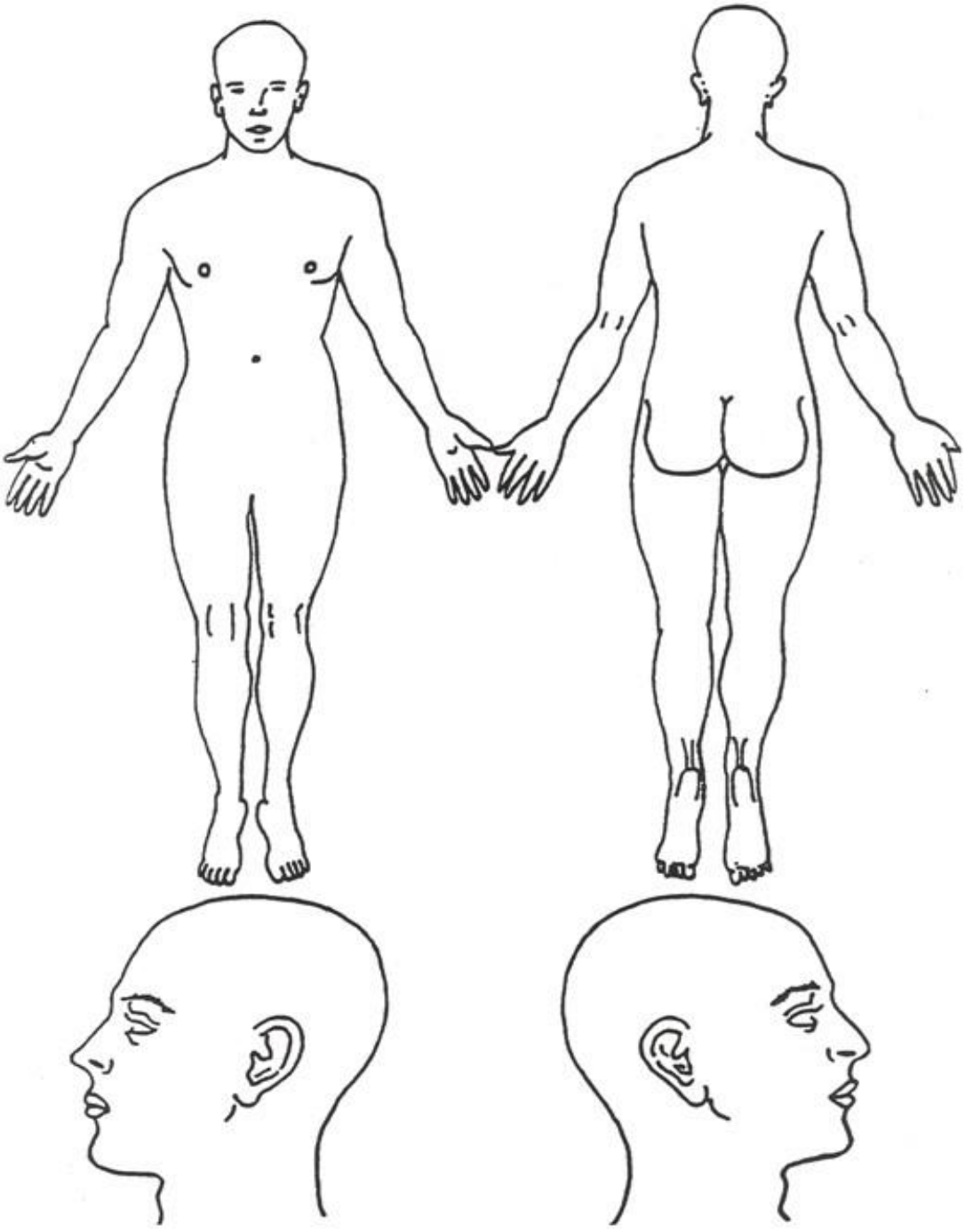
32. CONTACT SURVEILLANCE, if not listed on page 1#18, or when more details are needed for the Follow-up. *A contact is any individual who has shared the same enclosed air space in a household or other enclosed environment for a prolonged period with a person who has an untreated case of HD.*

Name Relation to Index	DOB	Inclusive Contact Dates From MM/YY	 To MM/YY	Address	Follow-up: Date and Status, if contact was assessed in clinic C = Case N = Negative, no signs/symptoms S = Suspicious Lesions

Name (Last, First) _____ *DOB:* _____

33.Date of Examination: ☐☐/☐☐/☐☐

(Mark on the below pictures any physical findings suggestive of Hansen's Disease)



Directions for this form

1. **Reporting State:** Use the abbreviation of the state from which the report is being sent. This is usually the state of the clinician's office and not necessarily the patient's resident state.
2. **Date of Report:** This is date of the initial LSF completion. If patient was previously reported and has relapsed, write the word "RELAPSE" next to the date.
3. Social Security Number: Optional; self-explanatory.
4. **Patient Name:** Self-explanatory.
5. **Present Address:** Please include the county and zip code which are used to geographically cluster patients.
6. **Place of Birth:** Include state and city, if born in the U.S., or the country, if foreign born.
7. **Date of Birth/Sex:** Self-explanatory.
8. **Race/Ethnicity:** This information should be voluntarily provided by the patient. If the patient refuses or indicates a race/ethnicity category not listed, check the "Not Specified" box.
9. **Date Entered the U.S.:** For patients who have immigrated to the U.S., provide the month and year of entry.
10. Date of Onset of Symptoms: This information is usually the patient's recollection of when classic leprosy symptoms *(rash, nodule formation, paresthesia, decreased peripheral sensation, etc.)* were first noticed.
11. **Date Leprosy First Diagnosed:** Provide the month and year a diagnosis was made. This usually coincides with a biopsy date if one was performed.
12. **How many doctors have you seen for this problem?** This will be based primarily on the patient's recollection. Include the physician reporting the case.
13. **Initial Diagnosis:** Was the patient diagnosed in the U.S. or outside the U.S.
14. **Type of Leprosy:** Classify the diagnosis based on one of the ICD-10-CM diagnosis codes. (NHDP Clinic physicians: Please circle specific classification, if possible)

    A30.5 Lepromatous Leprosy *(macular, diffuse, infiltrated, nodular, neuritic – includes Ridley-Jopling [RJ], Lepromatous [LL] and* A30.4 Borderline lepromatous *[BL]*): A form marked by erythematous macules, generalized papular and nodular lesions, and variously by upper respiratory infiltration, nodules on conjunctiva or sclera, and motor loss.
    A30.1 Tuberculoid Leprosy *(macular, maculoanesthetic, major, minor, neuritic – includes RJTuberculoid [TT] and* A30.2 Borderline tuberculoid *[BT])*: A form marked by usually one lesion with well-defined margins with scaly surface and local tender cutaneous or peripheral nerves.
    A30.0 Indeterminate *(uncharacteristic, macular, neuritic)*: A form marked by one or more macular lesions, which may have slight erythema.
    A30.3 Borderline *(dimorphous, infiltrated, neuritic – includes RJ Borderline [BB] or true mid disease only)*: A form marked by early nerve involvement and lesions of varying stages.
    A30.8 Other Specified Leprosy: Use this code when the diagnosis is specified as "leprosy" but is not listed above *(A30.0-A30.3)*, including 'pure neural' disease.
    A30.9 Leprosy, Unspecified: Use this code when the diagnosis is identified as "leprosy" but inactive.
15. Diagnosis of Disease: Reaction=Y if steroids required. Enter INITIAL biopsy and skin smear dates and results.
16. **Residence *(Pre-diagnosis)*:** List all cities, counties, and states in the U.S. and all foreign countries a patient resided in BEFORE leprosy was diagnosed. This information is used to map all places where U.S. leprosy cases have resided.
17. **Disability: Eye, Hand & Foot.** For each eye, hand and foot check Yes or No. [Normal always = No]
    Loss of any sensation in hands or feet; for Eyes, is blinking abnormal (very infrequent?). Normal = No
    Visible deformity (muscle wasting, clawing of fingers or toes, ulcers or other abnormality of the hands or feet. For Eyes, lagophthalmos or reduced vision (e.g. cataract). Normal = No
18. Current Household Contacts: Self-explanatory.
19. Current Treatment for Leprosy: Date that treatment started and indicate all drugs used for initial treatment.
20. Name and address of Physician: write contact information for the treating physician, and indicate if they are the investigator for clofazimine.
21. – 30. Self-explanatory

Directions for this form (continued)

31. Known contact with Hansen's Disease Case? Indicate if patient is a contact to someone with diagnosed Hansen's Disease. If yes, include suspected source information.
32. Contact surveillance: for contacts not listed on page 1, or when more information is known regarding the status of the contact, list all requested fields.
33. Date of Examination: date of physical exam by physician or HD clinic. Mark/draw on the body part to indicate where signs or symptoms of leprosy occur (rash, nodule formation, paresthesia, decreased peripheral sensation, etc.).