



### Tuberculosis (TB) Corrections Incident Report

Complete this form to report media sensitive exposures or exposures with > 50 contacts in a correctional facility. Please attach the form to the NEDSS investigation and send email notification to [TBEpi@dshs.texas.gov](mailto:TBEpi@dshs.texas.gov) within 48 hours of incident. Fields may be left blank if information is pending.

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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
DOB:	NEDSS Investigation ID:	TST Date Placed:	TST Date Read:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other:		Results (mm):	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Country of Birth:		IGRA Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Indeterminate/Borderline <input type="checkbox"/> Not Performed	
If not U.S., Arrival Date:		IGRA Test Date:	
Symptom Onset Date:		IGRA Test Type: <input type="checkbox"/> T-SPOT <input type="checkbox"/> QFT <input type="checkbox"/> Unknown	
TB Symptoms: <input type="checkbox"/> Cough <input type="checkbox"/> Chills <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Night Sweats <input type="checkbox"/> Weight Loss <input type="checkbox"/> Other, please specify:		AFB Specimen Site: Collection Date:	
Symptom End Date:		Specimen sent to DSHS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes, Dates: _____ to _____		AFB Sputum Smear Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Not Performed	
Name of Hospital:		Sputum Smear Conversion Date:	
Incarceration Date:		NAAT Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Not Performed	
TB Status at Intake: <input type="checkbox"/> Previous Positive <input type="checkbox"/> TB Disease <input type="checkbox"/> Previous TB Case <input type="checkbox"/> LTBI <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		AFB Culture Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Not Performed	
Infectious? <input type="checkbox"/> No <input type="checkbox"/> Yes, Dates: _____ to _____		Chest Imaging Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Isolated? <input type="checkbox"/> No <input type="checkbox"/> Yes, Dates: _____ to _____		Chest Imaging Type:	
If yes, isolation room type:		Date:	Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Correctional Release Date:		Cavitary? <input type="checkbox"/> Yes <input type="checkbox"/> No	Miliary? <input type="checkbox"/> Yes <input type="checkbox"/> No
Started on Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Case Died? <input type="checkbox"/> No <input type="checkbox"/> Yes, Date:	
Start Date:	End Date:	Was TB diagnosed at death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Started on RIPE? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Was TB cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If not RIPE, specify regimen:			
Comments:			



C. Exposure Location Information			
<b>Site Name:</b>		<b>Site Location:</b>	
Exposure Dates: _____ to _____		Site Visit Performed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Site Visit Date:
Correctional Facility Type: <input type="checkbox"/> Local <input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> Juvenile <input type="checkbox"/> Other, specify:			
Institution Leading Contact Investigation <input type="checkbox"/> Local/Regional Health Department <input type="checkbox"/> Correctional Institution			
Housing History During Infectious Period (Select all that apply): <input type="checkbox"/> Dormitory <input type="checkbox"/> Open Bay <input type="checkbox"/> Shared Cell < 4 people <input type="checkbox"/> Shared cell > 4 people <input type="checkbox"/> Other, specify:			
<b>Work Assignments:</b>			
Total # Contacts:	#High Priority:	#Medium Priority:	#Low Priority:
Please describe site environment(s) (i.e. large vs. small room, ventilation details, etc.)			
<b>Site Name:</b>		<b>Site Location:</b>	
Exposure Dates: _____ to _____		Site Visit Performed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Site Visit Date:
Correctional Facility Type: <input type="checkbox"/> Local <input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> Juvenile <input type="checkbox"/> Other, specify:			
Institution Leading Contact Investigation <input type="checkbox"/> Local/Regional Health Department <input type="checkbox"/> Correctional Institution			
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<b>Work Assignments:</b>			
Total # Contacts:	#High Priority:	#Medium Priority:	#Low Priority:
Please describe site environment(s) (i.e. large vs. small room, ventilation details, etc.)			
<b>Investigation Activities</b>			
Provide a timeline for all screening activities (completed and anticipated). Include specific dates where possible.			
<b>Media Involvement</b>			
Has the media become involved with this incident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Possible			
If yes, provide the name of media source and media contact person (if available) or all media involved:			