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KEY to Symbols

Pay particular attention

Remember to save the patient record

CDC RVCT Manual: [CDC RVCT Manual](#)

Questions?
Contact the Washington State Department of Health TB Program
Email [TBServices@doh.wa.gov](mailto:TBServices@doh.wa.gov), Phone: (206) 418-5500
Getting Started

The Washington Disease Reporting System (WDRS) TB Disease module is used to report suspect and confirmed cases of Tuberculosis (TB). This database can also be used to record TB infection and TB contacts. When logging into Secure Access Washington (SAW), adjust your Compatibility View settings in Internet Explorer to avoid WDRS freezing issues by clicking on the “Tools” icon on the top right hand corner of the page. Select Compatibility View settings from the dropdown menu and a pop-up menu will appear.

Select wa.gov from the “Add this website” window and click on the “Add” button to drop the website down to the “Websites you’ve added to Compatibility View” field. Click the “Close” button and continue to log into SAW as normal.
CRITICAL: Always disable the autofill feature in your browser before using WDRS.

Once you are logged into WDRS through SAW, search for a patient or create a new patient record from the WDRS Home screen. For guidance on how to Create a New Event (Patient Record) or Search for a Person in this reporting database, refer to the general WDRS Reference Guide. A view of the WDRS Home screen is shown below.

CRITICAL: Always search for an existing event or person, before creating a new event or person.

WDRS Workflows

IMPORTANT:
On the WDRS Home screen note the “Workflow Queue.” Workflows notify WDRS users of their events (e.g. cases and contacts) that need particular attention. Each workflow is specific to a certain scenario or set of criteria. The complete set of all your workflows can be viewed in two ways.

- By clicking on the workflows icon
- By clicking on “More …”
The “Workflow Queues” page lists the entire set of all workflows. Workflows related to management of your events are organized under **Case Specific Monitors**, **Open Events [LHJ]**, **Action Required [LHJ]**, and **Task Specific Monitors**.

**Case Specific Monitors**: includes workflows of open cases assigned to the current user, shared with others by the current user, or shared with the current user and user group(s) they belong to.

**Open Events [LHJ]**: includes workflows of all TB events currently open (also referred to as “active”) for their entire LHJ, and those in which the current user is the assigned investigator.

**Action Required [LHJ]**: includes workflows of TB events that the user’s LHJ are accountable for, requiring specific action(s) to be taken. These workflows are ordered by the level of priority that should be given to the action(s) required.
• **Task Specific Monitors**: includes workflows for open or overdue tasks that have been assigned to the current user or user group(s) they belong to, or created by the current user.

Adjacent to the hyperlink that opens each workflow, the “Workflow Queues” page also provides the total count of your cases currently in each workflow, the level of priority that should be given to each workflow, and the date workflow entries have been updated. Once on the “Workflow Queues” page you can limit your view to only those active workflows that contain one or more of your cases by clicking on “(Hide empty workflows).” A list of all workflows specific to action(s) that may be required of your LHJ is below. This listing includes the workflow name, the level of priority users should give to the workflow, a description of events in the workflow, and action(s) required to resolve the particular TB event(s) and clear them from the given workflow.

Workflows under **Action Required [LHJ]**:

- **TB Disease events that are still suspect >60 days [LHJ]**; priority “Very High”: cases of TB disease in which the verification status remains pending, 60 or more days after being created. To resolve a case record in this workflow:
  - First, ensure that results from all diagnostic testing performed to date have been entered in the case record. When diagnostic data in the case record are sufficient to verify a case, WDRS will automatically update the value of “Verification status” to a value other than “Suspect.”
  - If the value of “Verification status” remains “Suspect,” review the case with the provider responsible for care to determine if “Verification status” should be over-written to either “Not a verified case” or “Provider diagnosis.” If so, contact the [DOH TB Program](#) to have the value over-written. See [Verification Status](#) below for further details.

- **TB Events with ELR fields to resolve [LHJ]**; priority “Very High”: TB events (disease, contact or infection) where automated processing (i.e. DRIVE) has not been able to resolve values for key lab reporting output fields (e.g. WDRS specimen type, WDRS test performed, test result). Events in this workflow need LHJ manual review of electronic lab reporting and resolution of output value(s).
**IMPORTANT:**
TB events in this workflow should be resolved *before* reviewing any events in the TB Events with lab reports for review [LHJ] workflow, described below in the following pages.

To resolve a record in the TB Events with ELR fields to resolve [LHJ] workflow:

- Open the “Lab Results” tab of the Event Summary screen.

| Labs | 
|---|---|
| Lab No. | Specimen collection date | WDRS specimen type | WDRS test performed | WDRS test result |
| 5 | 12/31/2019 | Tissue or fluid | AFB smear | Positive |
| 6 | 12/31/2019 | Tissue or fluid | Automated process-unresolved | Automated process-unresolved |
| 7 | 12/31/2019 | Tissue or fluid | Automated process-unresolved | Automated process-unresolved |

- Review the numbered line list of ELR lab report entries in the “Labs” section, for any entries showing “Automated process-unresolved” in any of the key lab reporting fields shown. Click to open each such lab entry, and then select the “WDRS ELR template.”
- Review information in the ELR template for any fields of “WDRS specimen type,” “WDRS test performed,” or “WDRS test result” showing the value “Automated process-unresolved.” Update each unresolved value to one consistent with ELR data contained in corresponding read-only fields in the template.
- After each unresolved value has been updated in the ELR template, update the value of “Lab report reviewed – LHJ” to “Yes,” click “Save,” and return to the Event Summary screen for the event.

- **TB Disease events that have not been submitted by LHJ > 60 days [LHJ]; priority “High”:** cases of TB disease pending an LHJ count status determination, 60 or more days after being created. To resolve a case record in this workflow:
  - Review the case with your TB program manager to determine if the case is or is not to be officially counted as a verified case of TB in your jurisdiction. Update the value of “Countable TB case (LHJ)” accordingly. See Countable TB Case (LHJ) below for further details.

- **TB Disease events that need susceptibilities [LHJ]; priority “High”:** cases of TB disease with a positive culture on record in which initial drug susceptibility testing results remain pending. To resolve a case record in this workflow:
  - Ensure that any initial drug-susceptibility testing (DST) results reported to date have been entered into the WDRS case record. *Remember* to check the case record’s Lab Results tab for any DST results reported electronically. Also see Initial drug susceptibility testing done? below for further details.
• **TB Contact events that are not evaluated > 60 days [LHJ]**; priority “Medium”: TB contacts that have not been fully evaluated, 60 or more days after being created. To resolve a contact record in this workflow:
  o Ensure the contact has receive a complete evaluation as per [CDC Guidelines for the Investigation of Contacts](https://www.cdc.gov/tb/publications/guidelines/index.html).
  o In the “Diagnostics and Evaluation” question package, select a value for “*Disposition*” consistent with findings from the evaluation once completed.

• **TB Disease events that need a contact investigation [LHJ]**; priority “Medium”: cases of TB disease that are sputum smear positive, where a contact investigation has not yet been initiated. To resolve a case record in this workflow:
  o If a contact investigation has been initiated, enter the date the investigation began in “Contact investigation start date.” See [Contact investigation start date](#) below for further details.
  o If a contact investigation has not yet been initiated, review the case with your TB program manager to discuss the need to initiate a contact investigation. If and when an investigation is initiated, enter the date the investigation began as detailed above.

• **TB Events with lab reports for review [LHJ]**; priority “Medium”: TB events (disease, contact or infection) that require LHJ review of lab report(s). To resolve a record in this workflow:
  o Open the “Lab Results” tab of the [Event Summary](#) screen.
  o Click on each numbered “Labs” entry and select the “WDRS ELR template.”
  o Review lab information in the ELR template.
  o In the ELR template, update the value of “Lab report reviewed – LHJ” to “Yes,” click “Save,” and return to the Event Summary screen for the event.
  o Go to the “Diagnostics and Evaluation” question package.
  o Click on “Expand Details” at the top right of the screen to display all labs entered in the lab template for the event. Enter lab results data into corresponding fields of the “Diagnostics and Evaluation” question package, as needed. See [Diagnostics and Evaluation](#) below for further details.
• **TB Infection events that have not completed treatment >9 months [LHJ]; priority “Medium”:** cases of TB infection that have not completed treatment more than 9 months after starting treatment. To resolve an infection record in this workflow:
  - Ensure data in the “Treatment” question package are as complete as possible.
  - If treatment has been completed or discontinued, select the most appropriate value for “*Reason therapy stopped or never started."

• **TB Disease events with legacy data unresolved [LHJ]; priority “Low”:** legacy cases of TB disease (i.e. first reported before launch of WDRS) in which certain data from the legacy case record were not accepted into WDRS. To resolve a case record in this workflow:
  - Open the “Legacy Data Question Package.”
  - Enter any non-missing values into the corresponding field of the WDRS case record.
  - Enter “Yes” for “Legacy data are resolved as possible.”

**Workflows under Open Events [LHJ]:**

• **TB Events open in my LHJ [LHJ]; priority “Medium”:** TB events (disease, contact, infection) that have not been closed by the accountable LHJ and remain active. To resolve a record in this workflow:
  - If the patient or person is no longer receiving follow-up or treatment for a TB condition, ensure that data in the record are as complete as possible.
  - In the “Additional Information” question package, enter “Yes” for “*LHJ close case.”

• **TB Events with Investigator of current user [LHJ]; priority “Medium”:** TB events (disease, contact, infection) for which the current user is the named Investigator.

Once you have found, or created a new, patient event (patient record), the Event Summary screen will be displayed, as pictured below.

**Note:** When communicating about a case or other TB event record (e.g. contact or infection), it is often most useful to use the record’s system-assigned Event ID. The record’s Event ID is the unique identifier WDRS assigns to each event, and is the most efficient means of searching for a TB event in WDRS. This number is listed at the top of the Event Summary page of the selected event.

**IMPORTANT:**
To help protect the confidentiality of a person’s health information when communicating with DOH or other WDRS users, it is recommended whenever possible to use the WDRS Event ID for identifying the event record(s) in question, as a preferred alternative to other record identifiers (e.g. State Case ID).
In the middle of the page, there is an “Event Data” tab with a series of Question Packages to add information about the TB disease case including: Administrative, Demographics, Risk, Diagnostics and Evaluation, Treatment, and Additional Information. Disregard the CDC Notification Question Package, which will be used by the DOH TB Program.

For each question package, information is provided for who performed the last update to the case record and when, along with the status of that question package.

In each question package, any question marked by an asterisk (*) indicates a RVCT (Report of Verified Case of Tuberculosis) CDC reporting field that must be completed before a case is closed. Until each of these fields is complete, the status in each question package will remain “Incomplete.” Each of these required RVCT fields can also be entered and viewed through the “Report of Verified Case of Tuberculosis (CDC RVCT Form) wizard tool,” accessed by way of the “Wizards” window at the bottom of the “Event Data” tab of the Event Summary screen. The following pages provide additional detail regarding the RVCT Wizard.
The Report of Verified Case of Tuberculosis (RVCT) Wizard

The “Report of Verified Case of Tuberculosis (CDC RVCT Form)” wizard tool is accessed by clicking in the “Wizards” window located at the bottom of the “Event Data” tab of the Event Summary screen, selecting the wizard tool, and clicking “View Wizard.”

PLEASE NOTE: The organization and flow of data entry in the “Report of Verified Case of Tuberculosis (CDC RVCT Form)” wizard matches that of the CDC RVCT Manual. While this organization and flow are very similar in the WDRS question packages, there are important points to keep in mind as you report, manage and complete a case record. For example:

- Certain essential operations, such as selecting a reporting address, can only be performed through the WDRS question packages (i.e. Administrative, see below).
- The CDC RVCT Form wizard does not include all data and other information important in reporting, managing and completing a case record.
- Data required for CDC reporting (i.e. marked by an asterisk “*”) entered into the WDRS question packages will copy into the corresponding field of the CDC RVCT Form wizard (and vice versa).

Because of this, it is most often necessary to begin a case record using the WDRS question packages. It is also recommended that the WDRS question packages serve as a user’s primary means of reporting, managing and completing a case record, at least until they become familiar with data and other information contained in the case record and how data must be entered. Information and instructions specific to each of the WDRS question packages follows. These instructions also apply to the entry of any data required for CDC reporting.

The Suspect TB Wizard

After a new TB disease event is created—but before the event is confirmed as a verified case of TB—initial event data can also be entered through the “Suspect TB Wizard” tool, also accessed in the wizards window. The Suspect TB wizard includes a minimal subset of information necessary to record and monitor a suspect case, but wholly-insufficient to manage a case once it is verified.
**IMPORTANT:**
Once a case’s verification status has been confirmed (e.g. Positive Culture), the Suspect TB Wizard should no longer be used for entry of data or case management.

**IMPORTANT:**
Once a case has been verified, jurisdictions **must** ensure all data required for CDC reporting (i.e. marked by an asterisk “*”) are complete before closing a case.

### The WDRS TB Question Packages

To open a Question Package, double click on the Question Package name or single click to highlight the name and click on the “View Question Package” button at the bottom of the list. Answer questions in order, from the top to bottom of the page. Some questions have additional drop down questions that may not be visible until you select and answer the question in view. For example, in the Risk question package, the question “*Resident of correctional facility at time of diagnosis?” must be answered “Yes” in order for related questions to appear (note that all questions are preceded by an asterisk “*”, as these are required RVCT data fields).

![Example of WDRS TB Question Package](image)

Also, some additional drop downs and answers will not appear unless you click “Save & Stay.”

**Please note:** As you enter data, also keep in mind that the WDRS system will automatically time-out after 20 minutes of inactivity. Be sure to save the data you input in each question package by either clicking on the “Save & Stay” button, or the “Save” button which returns you to the **Event Summary** screen.
**IMPORTANT — Regarding the entry of calendar date values:**

Every effort should be made to determine a complete (i.e. mm/dd/yyyy), exact date value for entry into WDRS. When other than self-reported by the patient, dates should come from an appropriate, documented source (e.g. medical records, lab report, death certificate). When a complete, exact date cannot be determined, follow these guidelines:

- If the month and year are known, but a value for day cannot be determined exactly, enter the first day of the month (i.e. 01).
- If the year is known, but values for day and month cannot be determined exactly, enter the first day of the first month for that year (i.e. 01/01).
- If the date is unknown entirely, enter 01/01/1900.

Additionally, some grayed-out fields do not allow changes to be made. If changes to these fields are needed, make the change on the page where the information was originally entered. For example, refer to the “Persons” tab on the Event Summary page to add addresses, or change vital demographics. Other grayed-out fields can only be changed by the Washington State Department of Health (DOH) TB Program.
Administrative Question Package

Administrative

Accountable County
This field is autofilled based on the reporting address of the patient, as entered when the event was originally created, or added after a case is transferred to another jurisdiction. To populate this field, an address entered for the person on record must be selected as the Reporting Address. Whenever possible, the address selected should be the person’s home address. A new current address should be added to the person record of the TB event, and selected as the new reporting address, whenever a case is transferred to another jurisdiction.

To do so, first click on Select reporting address, which will open a pop-up window for selecting an official address for reporting, as shown below.

Click on Select an Official Address next to the correct address for reporting purposes. This will populate fields in the address section, and “Accountable County” on the Administrative page.
Selecting an official address for reporting purposes will also autopopulate fields in Address Reporting.

**Within City Limits**
This field is a requirement from CDC and must be selected on an individual basis. If the patient moves during therapy, be sure to add the new address and answer questions related to moving during therapy in the “Demographics” question package.

**Is treatment address different than reporting address?**
Select “No,” if addresses do not differ. Select “Yes,” if the patient is being treated at a different location than the patient's residence being reported in records, labs, etc.

**Is current address different that reporting address?**
Select “No,” if addresses do not differ. Select “Yes,” if addresses do differ. For instance, this area can be useful if a patient is currently staying at a nursing home and is retaining their primary residence. Again, this address must be added to the “Persons” tab before this optional address is available.
To edit or add an address, you will need to navigate back to the “Persons” tab in the Event Summary screen, shown below.

Next, click on the “Address Information” tab, which will show a screen in which you can either edit an existing address on record, or add an address (such as when the person on record moves to another jurisdiction).

**NOTE**: if the patient is experiencing homelessness at the time of diagnosis, enter the City, County and Zip Code of the shelter or area where the patient was living at diagnosis. Also indicate “Residence Type” as “Homeless.”
Please note, user access to cases is based on the jurisdiction named in the “Accountable County” field, when a case is first counted, as well as when the accountable county may change if a case is transferred to another jurisdiction after being counted. Users are able to view, and edit, cases in which their LHJ is the named “Accountable County” at the time of case counting, or after being transferred to their jurisdiction once counted. To ensure a case is accessible to the appropriate jurisdiction(s) throughout the course of case management, an accurate, current address must be selected as the reporting address. “Accountable County” can be over-written using the field to the right labeled “Override Accountable County” as explained below.

**Override Accountable County – DOH Only**
This field is available to override the “Accountable County,” in the instance that the person is not being cared for in their county of residence. For example, if a patient lives in Snohomish County but is being cared for at Harborview Medical Center in King County, and King County is going to count the case, this field will allow King County to be selected as the Accountable County. If this field needs to be utilized, contact the DOH TB Program.

**Investigator** This field is entered based on the primary data case manager for this case. This can be changed to another investigator in your jurisdiction. For case transfers outside of your jurisdiction, contact the DOH TB Program. Adding an investigator helps the DOH TB Program know who to contact regarding data in the record and also affects workflows available to data case managers.

To enter the individual acting as investigator for the case, select the search icon which will open a separate search window in which you can search by Username, Last Name, and First Name.

**Local Health Jurisdiction (LHJ) Notification Date**
Enter the date the LHJ was first notified of a suspect or confirmed case of tuberculosis.

LHJ notification date based on
Indicate the way in which your LHJ received notification of the case, by either phone, fax, email, or lab test result.

**Date LHJ notified DOH**
This is the date your LHJ first notified the DOH TB Program of the case. This date defaults to the current date, but can be changed manually.
**Verification status**
Upon first creating the case record, the value will be set to “Suspect.” As lab and other diagnostic data are completed in the case record, this field will autofill with the value set along a CDC-defined hierarchy of clinical evidence confirming the case as verifiable (i.e. Positive Culture, Positive NAA, Positive Smear or Tissue, Clinical Case Definition). The value of verification status is automatically set to “Not a Verified Case” when the question “Reason therapy stopped or never started” is answered as “Not TB.” For more information, see the [CDC RVCT Manual](#) (page 205).

**Verification status over written**
There are two instances when a verification status value of “Suspect” can be overwritten; to either:

(1) **Not a Verified Case**: When a case is determined to not be TB.

OR

(2) **Verified by Provider Diagnosis**: Based on the provider’s clinical judgement, when diagnostic data are not sufficient to otherwise verify the case.

If the value of verification status needs to be over-written, please contact the [DOH TB Program](#).

**Countable TB Case (LHJ)**
When a case is ready to be counted, the accountable LHJ must select “Yes.” This will send the case to a workflow managed by the DOH TB Program.

Alternatively, if the case will not be counted, select “No.”

**Non-countable TB case (LHJ)**
Cases are non-countable for one of the reasons below. Select the most appropriate reason for not counting the case.

(1) **Verified case: counted by another U.S. area** (e.g., another state, or U.S. territory)

*Note*: see Linking Case Number below.

(2) **Verified case: Recurrent TB within 12 months after completion of therapy**

*Note*: see Linking Case Number below.

(3) **Verified case: TB treatment initiated in another country** (if selected, drop down to select country will appear).
Refer to the [CDC RVCT Manual](#) (page 41) for additional details.

**Countable TB Case (DOH only)**

The DOH TB Program will be notified via a workflow that a case is ready to be counted and will review the case information. Cases are counted at the beginning of the week if they meet counting requirements as per CDC. The DOH TB Program will contact the listed investigator if further information is needed prior to being counted.

**Date counted**

This is the date that DOH uses in a weekly count to send data to CDC and will be reflected in the CDC MMWR. This date is hidden to standard users as it is only for surveillance purposes and is not clinically relevant to the case.

<table>
<thead>
<tr>
<th>Case Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Countable TB case (LHJ)</td>
</tr>
<tr>
<td>Countable TB case</td>
</tr>
<tr>
<td>Date counted</td>
</tr>
<tr>
<td>Accountable county at time case counted</td>
</tr>
</tbody>
</table>

**State Case Number**

This field is hidden until both the LHJ and DOH select “Yes” to officially count the case. When both fields are selected “Yes,” a state case number autogenerates and the case number will appear.

**County Case Number**

This field is available to LHJs that assign their own case numbers for their own documentation.

<table>
<thead>
<tr>
<th>Transfer state case number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linking case number</td>
</tr>
<tr>
<td>Reason</td>
</tr>
</tbody>
</table>

**Transfer Case Number**

Assigned only by the DOH TB Program — when a case is being transferred into Washington State, either from another U.S. state or territory, or from another country.
**Linking Case Number**

Refer to the [CDC RVCT Manual](#) (page 28) for instructions on how to link cases. This field links cases for the following reasons:

- Recurrence, or previous diagnosis of TB (i.e. recurrent diagnosis of TB disease in the same patient, within 12 months after the patient completed therapy for the initial episode of TB disease).
  - **Note**: the corresponding Linking Case Number **must** be the RVCT State Case Number assigned to the initial episode.

- Epidemiologically linked case
  - **Note**: the corresponding Linking Case Number **must** be the RVCT State Case Number assigned to the epidemiologically linked case.

- Case transferred from another area
  - **Note**: the Linking Case Number **must** be the RVCT State Case Number assigned by the U.S. state or territory initially counting the case.

- Other
  - If selected, a comment box will appear to specify the reason for linkage.

If more than one linked case is needed, the “Add New” link will provide drop down fields to do so.

**Comments**

![Comments](#)

**Comments and command buttons**

Insert additional comments in this field. Click “Save” button to save your changes and return to the Event Summary screen. A “Cancel” and “Help” button are also available options.
Demographics Question Package

Patient Name at Event

<table>
<thead>
<tr>
<th>Patient Name at Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name</td>
</tr>
<tr>
<td>Middle name</td>
</tr>
<tr>
<td>Last name</td>
</tr>
</tbody>
</table>

First Name, Middle Name, and Last Name.
Fields autofill from contact names entered in the Person page when a new event was created. To edit name information, return to the Event Summary page and select the “Persons” tab. Click the “Edit Person” button to manage information about the patient.

General Demographics

<table>
<thead>
<tr>
<th>General Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>* U.S. born (or born abroad to a parent who was a U.S. citizen)</td>
</tr>
<tr>
<td>Month arrived in US</td>
</tr>
<tr>
<td>Year arrived in US</td>
</tr>
<tr>
<td>* Country of birth</td>
</tr>
<tr>
<td>Preferred language</td>
</tr>
<tr>
<td>Interpreter needed?</td>
</tr>
<tr>
<td>Marital Status</td>
</tr>
<tr>
<td>* Ethnicity</td>
</tr>
<tr>
<td>* Race</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Sex at birth</td>
</tr>
</tbody>
</table>

U.S. Born (or born abroad to a parent who was a U.S. citizen)
Select “Yes,” if the person was born in 1 of the 50 U.S. states, the District of Columbia, or a U.S. territory; or if they were born abroad to a U.S. citizen parent. Select “No” if the person was born abroad and neither parent is or was a U.S. citizen. If “No” is selected, further questions (listed below) will appear for data entry.
Month and Year arrived in U.S.
If the patient was born abroad (whether to U.S. citizen(s) or not) enter the month and year the patient first arrived in the U.S. **Note:** if the patient is born abroad to a U.S. citizen parent, this date must be filled out for when they actually entered the U.S. For more information on this question in the [CDC RVCT Manual](https://www.cdc.gov/vhf/rvct_manual/chapter4.html) (page 68).

| * U.S. born (or born abroad to a parent who was a U.S. citizen) | **No** |
| * Month arrived in US |  |
| * Year arrived in US |  |
| TB classification at immigration |  |
| Overseas chest radiograph available? |  |
| * Country of birth |  |
| Preferred language |  |
| Interpreter needed? |  |
| Marital Status |  |

If the patient is not “U.S. Born” they may enter the U.S. under a specific immigrant classification based on their overseas TB screening. Upon evaluation in the U.S., you may receive or they may provide you with follow-up paperwork regarding their TB status. Their status should be indicated on their paperwork. For more information on these classification types, refer to [CDC Domestic Tuberculosis Guidelines](https://www.cdc.gov/tb/topic/guidelines/index.htm) for further details. If the person has been in the country for an extended period and is unsure of their status, contact the [DOH TB Program](https://www.doh.wa.gov).  

**TB classification at immigration:**
Indicate the patient’s TB classification at immigration, if any, from the following choices:

- A - TB with waiver
- B1 - Pulmonary TB
- B1 - Extrapulmonary TB  

- B2 – Infection Evaluation (LTBI)
- B3 - Contact Evaluation

**Overseas chest radiograph available?**
If the patient recently immigrated to the U.S., they may have entered with an overseas chest radiograph. Knowledge and availability of this chest radiograph may be useful in the assessment of TB status. This would also be especially useful if the primary reason evaluated for TB disease was “Immigration medical exam.”
Country of birth

Country of birth must be indicated regardless of U.S. born status. This includes those born in one of the 50 states, or the District of Columbia, in which you would indicate “USA” as their country of birth.

Preferred language

Indicate the language the patient prefers for communication by selecting the search icon and entering for the name of the language.

If you are unsure of spelling you can use the “wildcard function,” by enter the first couple letters of the word you are searching for followed by an asterisk (e.g. for a search of Burmese you could type bu*), while choosing the Match Type as “Starts With.” This would pull up all languages that start with “Bu”).

Once you have found the language desired, select from the list generated by double clicking on the language or single click on the language and click the “Select” button. You can remove languages with the trash icon next to the window.

Interpreter needed

Select “Yes”, “No”, or “Unknown” if the patient needs or prefers an interpreter for services.
**Marital status**
If marital status is unknown, leave selection blank. Other options include:

- Single
- Married
- Divorced
- Widowed

**Ethnicity**
Choose “Hispanic or Latino,” or “Not Hispanic or Latino.” This field is self-reported. The “Hispanic or Latino” description includes if the patient considers themselves Cuban, Mexican, Puerto Rican, South or Central American, or of other Spanish culture or origin, regardless of race. See [CDC RVCT Manual](#) (page 58) for details.

**Race**
This field is also self-reported and allows for one or more selections, including: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, or White. If “Asian,” or “Native Hawaiian or Other Pacific Islander” are selected, drop downs will appear to further specify race. For definitions of each category visit the [CDC RVCT Manual](#) (page 60).

**Sex at birth**
This field will autofill based on the sex selected on the initial Person page upon being created. It should be entered as the sex of the patient at birth.

To edit “Sex at birth” information, return to the Event Summary page and select the “Persons” tab. Click the “Edit Person” button to manage information about the patient.
Patient Location

<table>
<thead>
<tr>
<th>* Did patient move during therapy?</th>
<th>Yes</th>
<th>Add New</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Where did patient move?</td>
<td>In state (out of jurisdiction)</td>
<td>Add New</td>
</tr>
<tr>
<td>* What county did patient move to?</td>
<td>King County</td>
<td></td>
</tr>
<tr>
<td>* What city did patient move to?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* If moved during treatment was interjurisdictional notification sent?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Date interjurisdictional notification sent</td>
<td>08/13/2019</td>
<td></td>
</tr>
</tbody>
</table>

Did patient move during therapy? Refer to the CDC RVCT Manual (page 174) for details.

If “Yes” is selected then a dropdown will appear to collect details.

Where did the patient move?
Options are:
- In state (out of jurisdiction)
- Out of State
- Out of Country

In addition, you can add additional moves if there were more than one, however, CDC will only collect data on the first two moves for each category.

What county or state or country did patient move to?
Enter the specific location, based on type of move.

If moved during treatment was interjurisdictional notification sent?
Options are “Yes,” and “No.”

Date interjurisdictional notification sent:
Specify date sent. For more information on how to fill out interjurisdictional notifications on relocations occurring within the U.S., visit the National Tuberculosis Controllers Association website.

IMPORTANT - whenever recording relocation of a patient within the U.S.:
(1) Make the WDRS case record as complete as possible, entering all relevant data (e.g. lab results), before transferring to another jurisdiction.
(2) Add the new destination address to the patient record using the Person screen, and select this address as the new reporting address. See Adding an address above for further detailed instructions.
**IMPORTANT**

International notification of relocations to another country should be communicated through the CDC and CureTB. Please refer to the CDC Cure TB website for further guidance and the appropriate notification form(s).

**Patient lived outside U.S. for >2 months?**

If “Yes,” specify country and click “Add New” if multiple countries are needed.

**Patient Age**

![Patient Age](image)

**Birthdate**

This field will autofill based on the birth date entered in the initial “Create Event – Person Information” page when the TB case was first created. To edit “Birth Date” information, return to the Event Summary page and select the “Persons” tab. Click the “Edit Person” button to manage information about the patient.

**Age of patient**

The field will autofill based on the birth date selected on the initial Person page when the TB case was first created.

**Is patient pediatric?**

This field will autofill if the patient is 15 years old or younger, and is based on the birth date selected on the initial Person page when the TB contact was created.

If the patient is pediatric, additional questions will be displayed for input:

- **Country of birth for primary guardian(s) and Additional county of birth for primary guardian(s)**
  
  Primary guardians include for example: mother, father, adoptive or foster parent, and grandparent. Enter the names of the countries where the primary guardian(s) were actually born. Limit entry to two parents and or primary guardians. If U.S. born, please indicate “USA.”
Patient Status

<table>
<thead>
<tr>
<th>Status at TB diagnosis</th>
<th>Dead</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Was TB a cause of death?</td>
<td></td>
</tr>
<tr>
<td>Date of death</td>
<td></td>
</tr>
</tbody>
</table>

Please fill in the date death information on Person Screen

Status at TB diagnosis
Indicate if the patient was “Alive,” or “Dead,” at diagnosis. Information on how to define status is available in the CDC RVCT Manual (page 75).

Was TB a cause of death?
This answer should reflect current active TB disease (not TB infection) as a cause of death or not, as documented in the corresponding death certificate whenever possible. Information classifying this distinction is available in the CDC RVCT Manual (page 76).

Date of Death
If the patient’s status at diagnosis is “Dead,” return to the Person record under the “Persons” tab, select “Edit Person,” and enter the death date, as documented in the corresponding death certificate whenever possible. The “Date of death” field in the Patient Status section will then autofill from the Person record. Remember to also update Vital Status to “Dead” in the Person record.
Patient Occupation

**Primary occupation within the past year**
Select the primary occupation within the 12 months before the diagnostic evaluation. If the patient held more than one occupation during that period, select the longest-held occupation or the occupation to which the patient devoted more time.

Dropdown Options: (see the CDC RVCT Manual, page 135, for further information)

- Health care worker
- Correction facility employee
- Migrant/Seasonal worker
- Retired
- Unemployed
- Not seeking employment (e.g., student)
- Unknown
- Other Occupation

**If currently employed, specify employer**
A comment box is available to indicate the name of the patient’s current employer.

**If currently a student, student status**
Indicate the patient’s current student status (if applicable). Dropdown Options:

- Daycare/preschool
- K-12
- College/grad school
- Unknown
Comments

Comments and command buttons

Insert additional comments in this field, if needed. Click “Save” button to save your changes and return to the Event Summary screen. A “Cancel” and “Help” button are also available options.
History

<table>
<thead>
<tr>
<th>History of BCG</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous exposure to TB before this incident</td>
<td>Yes</td>
</tr>
<tr>
<td>&quot;Does patient have previous history of TB disease?&quot;</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Year of previous TB disease diagnosis (yyyy)*

| 2000 | Add New |

Previous treatment completed for TB disease?

| Yes |

| Year of previous TB treatment (yyyy) | 2000 | Add New |

Does patient have previous history of TB infection?

| Yes |

| Year of previous TB infection diagnosis (yyyy) | 1999 | Add New |

Previous treatment completed for TB infection?

| Yes |

| Year of previous treatment for TB infection (yyyy) | 1999 | Add New |

History of BCG

Indicate if the patient self-reports receiving the Bacillus Calmette–Guérin (BCG) vaccine, which is primarily given to newborns in countries where TB is common. For a list of these countries and current practices, visit the BCG Atlas. **Note:** BCG has also been used as part of treatment for bladder cancer. Genotyping can confirm this strain of BCG-related Bovis, which is not a notifiable condition. See CDC RVCT Manual (pages 205–206) for further details.

Previous exposure to TB before this incident?

If known, indicate whether or not the patient has experienced exposure to active TB disease prior to the current episode.

Does patient have previous history of TB disease?

If “Yes,” additional questions will appear:

- **Year of previous TB (disease) diagnosis (yyyy).**
  Indicate the year the patient was previously diagnosed with TB disease.
  - If unknown, leave blank.
  - If the patient has been diagnosed more than once, select “Add New” to enter the additional diagnosis information in ascending chronological order.
Previous treatment completed for TB disease?  
If “Yes,” these additional questions will appear:

Year of previous TB treatment (yyyy)
- Enter the year that the previous treatment for TB disease was completed. If unknown, leave blank.
- If the patient has completed treatment for TB disease more than once, select “Add New” to enter the additional treatment year.

Does patient have previous history of TB infection?  
If “Yes,” these additional questions will appear:

Year of previous TB (infection) diagnosis (yyyy)
- Enter the year the patient was previously diagnosed with TB infection.
- If the patient has been diagnosed with TB infection more than once, select “Add New” to enter the additional diagnosis information in ascending chronological order.

Previous treatment completed for TB infection?  
If “Yes,” these additional questions will appear:

- Year of previous treatment for TB infection (yyyy)  
Enter the year that the previous treatment for TB infection was completed.
- If the patient has completed TB infection treatment more than once, select “Add New” to enter the additional treatment year.
Risk

Patient lived or worked in a country with high prevalence of TB disease within the past 5 years?
If “Yes,” an additional question will appear:

Specify countries
Select all countries in which the patient lived or worked within the past 5 years that have been identified as a WHO high prevalence disease area. The 30 TB High Burden Countries used by WHO 2016-2020 can be found at: WHO TB High Burden Country Lists 2016-2020.

Homeless within past year?
Indicate “Yes” if the patient was homeless at any time during the 12 months before the TB diagnostic evaluation was performed or initiated. For further details see CDC RVCT Manual (page 125).

Resident of correctional facility at time of diagnosis?
If “Yes,” additional questions appear:

Type of correctional facility:
Select one of the options:

- Federal prison
- State prison
- Local jail
- Juvenile correction facility
- Unknown
- Other correctional facility

If “Other Correctional Facility” is selected, a comment box will appear to add free text specifying the type of facility. For a more detailed list, see the CDC RVCT Manual (pages 128–129).
Under custody of Immigration and Customs Enforcement (ICE)?
Response indicates whether the patient was under the custody of ICE at the time of diagnosis. Persons in ICE custody can be housed in standalone ICE detention centers, or other correctional facilities (e.g., federal or state prison, local jail) when a standalone ICE detention center is not available.

Resident of long-term care facility at time of diagnosis?
If “Yes,” options to specify type of long-term care facility appear:

Select one of the options:
- Nursing home
- Hospital-based Facility
- Resident facility
- Mental health residential facility
- Alcohol or drug treatment facility
- Unknown
- Other long-term care facility

If “Other long-term care facility” is selected a comment box will appear to allow you to specify what type of “Other long-term care facility” the patient was in. This category is for any facility not listed that is designated for a period of care of 30 days or longer.

Has patient ever used tobacco?
Select one of these options:
- Never
- Past use
- Current use
- Unknown

If “Past use” or “Current use” is selected, additional questions will appear.

Packs per day
Selections include “<1,” “1,” “2,” “3 or more,” or “Not applicable.”
Years of tobacco use
Type the number of years, using the digit keys. Example: “5” instead of “five”

Has patient ever used marijuana?
If “Past use” or “Current use” is selected, the following question will appear:

Specify Frequency of use
Selections include “Less than once/month,” “Monthly,” “Weekly,” or “Daily.”

Excess alcohol use within past year?
Indicate whether or not the patient has consumed alcohol to excess within the 12 months prior to diagnosis. If “Yes” is selected, the following question will appear:

Alcoholic drinks per week
Enter the number of alcoholic drinks, on average, the patient reports consuming per week.

Non-Injecting drug use within past year?
Specify “Yes,” “No,” or “Unknown.” Non-injecting drug use includes the use of prescription or illegal drugs not prescribed by a provider that were not administered by hypodermic needle.

Injecting drug use within past year?
Specify “Yes,” “No,” or “Unknown.” Injecting drug use involves the use drugs not prescribed by a provider, administered by hypodermic needle.

HIV status at time of diagnosis?
Select from the following options:

Positive
Opens these additional questions to specify:
- Date of first positive test
- CD4 count
- State HIV/AIDS patient number
- City/County HIV/AIDS patient number
Negative
   o Specify date of most recent negative test

The following other options do not have additional questions:
   • Indeterminate (HIV test was performed at the time of TB diagnosis, with documented indeterminate results)
   • Refused (HIV test was offered to the patient at the time of TB diagnosis, but refused)
   • Not offered (HIV test was not offered to the patient at the time of TB diagnosis)
   • Test done, results unknown (HIV test was performed at the time of TB diagnosis, but the results remain unknown for a reason other than being pending)
   • Unknown (Note: select only when none of the above responses apply, when it is not known whether the patient has ever had an HIV test, has ever been offered an HIV test, or was ever referred to HIV counseling and testing).

Refer to the CDC RVCT Manual (page 122) for further details.

Additional Risk Factors

<table>
<thead>
<tr>
<th>Additional Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
<tr>
<td>□ Yes</td>
</tr>
</tbody>
</table>

Select none above or at least one of the following risk factors.

- Contact of MDR TB patient (2 years or less)  □ Yes
- Contact of infectious TB Patient (2 years or less)  □ Yes
- Missed contact (2 years or less)  □ Yes
- Incomplete treatment of TB infection  □ Yes
- TNF-Antagonist therapy  □ Yes
- Post-organ transplantation  □ Yes
- Diabetes Mellitus  □ Yes
- End-Stage renal disease  □ Yes
- Immunosuppression (Not HIV/AIDS)  □ Yes
- Additional TB risk factors?  □ Yes

Specify

Check the corresponding box if any of the following apply to your patient:
   • Select “None” if none of the other listed risk factors apply.
Otherwise, indicate any and all other listed risk factors that apply at the time if diagnosis.

- Contact of MDR TB patient (2 years or less)
- Contact of infectious TB Patient (2 years or less)
- Missed contact (2 years or less)
- Incomplete LBTI treatment
- TNF-Antagonist therapy
- Post-organ transplantation
- Diabetes Mellitus
- End-Stage renal disease
- Immunosuppression (Not HIV/AIDS)
- Additional TB risk factors? - This will prompt a free text window to appear to specify further.

### Medical History

<table>
<thead>
<tr>
<th>Medical History</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Hepatitis</td>
<td>✔</td>
</tr>
<tr>
<td>Weight at least 10% less than ideal body weight</td>
<td>✔</td>
</tr>
<tr>
<td>Behavioral health issues</td>
<td></td>
</tr>
<tr>
<td>Skin disease</td>
<td>✔</td>
</tr>
<tr>
<td>Hypertension/CVA</td>
<td>✔</td>
</tr>
<tr>
<td>Heart disease/PVD</td>
<td>✔</td>
</tr>
<tr>
<td>Thyroid disease/dysfunction</td>
<td></td>
</tr>
<tr>
<td>Neurological disorder/seizures</td>
<td>✔</td>
</tr>
<tr>
<td>Vision/Hearing disorder</td>
<td>✔</td>
</tr>
<tr>
<td>Leukemia</td>
<td>✔</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>✔</td>
</tr>
<tr>
<td>Cancer</td>
<td>✔</td>
</tr>
<tr>
<td>Liver disease</td>
<td>✔</td>
</tr>
<tr>
<td>Autoimmune disease</td>
<td>✔</td>
</tr>
<tr>
<td>Arthritis</td>
<td>✔</td>
</tr>
<tr>
<td>Chronic Malabsorption Syndrome</td>
<td></td>
</tr>
<tr>
<td>Medical history other</td>
<td></td>
</tr>
</tbody>
</table>

Record each of the listed conditions as “Yes,” “No,” or “Unknown,” for being present in the patient’s known medical history.
History of Hepatitis?
If “Yes” the following question will appear:

Hepatitis type?
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Drug induced Hepatitis
- Non specified Hepatitis

Other Conditions:
- Weight at least 10% less than ideal body weight
- Behavioral health issues
- Skin disease
- Hypertension/CVA
- Heart disease/PVD
- Thyroid disease/dysfunction
- Neurological disorder/seizures
- Vision/Hearing disorder
- Leukemia
- Lymphoma
- Cancer
- Liver disease
- Autoimmune disease
- Arthritis
- Chronic Malabsorption Syndrome
- Medical history other (if “Yes” specify details)

Comments

Comments and command buttons
Insert additional comments in this field, if needed. Click “Save” button to save your changes and return to the Event Summary screen. A “Cancel” and “Help” button are also available options.
Diagnostics and Evaluation Question Package

Evaluation

Date patient presented to health care system
Specify the date the patient first presented to the health care system in relation to the current diagnosis.

Primary reason evaluated for TB Disease
Select one of the following: (Refer to the CDC RVCT Manual, page 116) for further details

- TB symptoms
- Abnormal chest radiograph (Consistent with TB)
- Contact investigation
- Targeted testing
- Health care worker
- Employment/Administrative testing
- Immigration medical exam
- Incidental lab result
- Unknown

Symptomatic?
If “Yes,” then indicate “Yes,” “No,” or “Unknown,” for each of the following symptoms:

- Cough > 3 weeks in duration
- Chest pain
- Coughing up blood/sputum
- Weakness/fatigue
- Unexplained weight loss
- No appetite
- Fever/chills
- Night sweats
- Other - Specify in free text window.
First symptom onset date
Enter date the patient recalls first experienced any of the symptoms reported.

Hospitalization

Patient hospitalized during current disease episode?
If “Yes,” additional question appear:

  Is hospitalization information available?
  If “Yes,” the following additional question appears. Multiple entries are possible by selecting the “Add New” link.

Hospital name
Use the search icon to select a hospital name.
If you are unsure of spelling you can use the “wildcard function,” by enter the first couple letters of the word you are searching for followed by an asterisk (e.g. for a search of Providence you could type Prov*). This would pull up all hospitals that start with “Prov”). For more information on this function see the WDRS Quick Reference Guide.
**IMPORTANT:**
When recording results of diagnostic tests, “Unknown” should only be recorded when it is unknown whether the test was performed, or results are unknown for reasons other than results are pending.

When it is known that a test was not performed, do not record “Unknown” — record “Not done” instead.

**TB Screening**

<table>
<thead>
<tr>
<th>Test Type</th>
<th>Result</th>
<th>Date Placed</th>
<th>Induration</th>
</tr>
</thead>
<tbody>
<tr>
<td>TST</td>
<td>Positive</td>
<td>08/19/1999</td>
<td></td>
</tr>
<tr>
<td>IGRA</td>
<td>Positive</td>
<td>08/25/1999</td>
<td></td>
</tr>
</tbody>
</table>

**TST at diagnosis:**
Select either:
- Positive
- Negative
- Not done
- Unknown

If “Positive” or “Negative” is selected:
- Date TST placed will appear for input.
  - Record date the TST was placed
  - Record millimeters (mm) of induration

**IGRA at diagnosis**
Select either
- Positive
- Negative
- Indeterminate
- Not done
- Unknown
If selecting “Positive,” “Negative,” or “Indeterminate,” enter:

- Record date the specimen was collected
- Record type of IGRA test

Current selection options include T-Spot and QFT-Gold. Additional tests will be added upon FDA approval and recommendation by CDC.

⚠️ If both TST and IGRA are designated “Not done”; Specify reason tests were not done.

Select from the following reasons:

- Refused
- Unable to locate
- No need for follow-up
- Greater than 8 weeks from last exposure
- Other (another window will appear to specify)

* Site of TB Disease (select all that apply)

- Pulmonary
- Pleural
- Lymphatic: Cervical
- Lymphatic: Intrathoracic
- Lymphatic: Axillary
- Lymphatic: Other
- Lymphatic: Unknown
- Laryngeal
- Bone and/or joint
- Genitourinary
- Meningeal
- Peritoneal
- Site not stated
- Other

Site of TB Disease (select all disease sites that apply)

- Pulmonary
- Pleural
- Lymphatic: Cervical
- Lymphatic: Intrathoracic
- Lymphatic: Axillary
- Lymphatic: Other
- Lymphatic: Unknown
- Laryngeal
- Bone, joint, and/or soft tissue
- Genitourinary
- Meningeal
- Peritoneal
- Site not stated
- Other
If selecting “Other” a dropdown list will appear for indicating the specific anatomic site of disease. Once a selection is made, a “Add New” link appears to indicate additional “Other” sites as indicated. **Note:** Selecting a site of disease is **required** for verifying a case under “Clinical Case Definition.”

See [CDC RVCT Manual](#) (page 78) for further details, and Appendix C (page 215) for expanded specific anatomic codes.

**IMPORTANT — When recording test results from multiple clinical specimens (i.e. sputum, tissue or fluid), collected 8 to 24 hours apart:**

Users are free to enter test results reported from each specimen — **however**, it is only required to enter test results reported from a single specimen. When selecting a single specimen test result to enter, the CDC guidelines below **must** be followed:

- **General rule:**
  - Any positive result supersedes all other test results (i.e. negative, indeterminate).

- **Specific to results from smear, pathology/cytology, and culture:**
  - If **any** result is positive, enter the test result as “Positive” and additional data (e.g. collection and result notification dates) corresponding to the positive specimen with the earliest collection date.
  - If **all** results are negative, enter the test result as “Negative” and additional data (e.g. collection and result notification dates) corresponding to the negative specimen with the earliest collection date.

- **Specific to results from nucleic acid amplification (NAA):**
  - If **any** result is positive, enter the test result as “Positive” and additional data (e.g. collection and result notification dates) corresponding to the positive specimen with the earliest collection date.
  - If **no** results are positive AND at least one result is negative, enter the test result as “Negative” and additional data (e.g. collection and result notification dates) corresponding to the negative specimen with the earliest collection date.
  - If **all** results are indeterminate, enter the test result as “Indeterminate.” Do not enter additional data (e.g. collection and result notification dates).

**CRITICAL:**

When recording initial diagnostic test results, clinical specimens should have been collected during the diagnostic evaluation, before the patient has started treatment, or has been on treatment for no more than 2 weeks. Results from specimens collected after 2 or more weeks of treatment should not be considered diagnostic.
Sputum smear
If “Positive” or “Negative,” record the following:

- Date collected
- Date lab received
- Specimen accession number
- Date LHJ notified of smear result

Subsequent results from later testing can be recorded by selecting the “Add New” link that appears adjacent to the most recent result on record.

Sputum culture
If “Positive” or “Negative,” record the following:

- Date collected
- Date lab received
- Specimen accession number
- Date LHJ notified of culture result
- Reporting laboratory type

Select laboratory type from the following options:

- Public health laboratory
- Commercial laboratory
- Other (field appears allowing you to specify laboratory type)

Reporting laboratory

Use the search icon to select a laboratory name. If you are unsure of spelling you can use the “wildcard function,” by enter the first couple letters of the word you are searching for followed by an asterisk (e.g. for a search of PacLab you could type PacL*). This would pull up all laboratories that start with “PacL”). For more information on this function see the WDRS Quick Reference Guide.

Subsequent results from later testing can be recorded by selecting the “Add New” link that appears adjacent to the most recent result on record.

Sputum culture conversion documented

If “Yes,” specify date isolate was collected for FIRST consistently negative sputum culture.

Note: culture conversion is defined as at least 1 negative sputum culture following an initial culture-positive result, with no positive cultures after the negative culture(s).

If “No,” document the reason conversion has not been documented from list below:

- No follow-up sputum despite induction
- No follow-up sputum and no induction
- Died
- Patient refused
- Patient lost to follow-up
- Unknown
- Other (additional window appears to specify “Other” reason)
**Smear/Pathology/Cytology of tissue and other bodily fluids:**

If “Positive” or “Negative,” record the following:

- Type of exam (Smear or Pathology/Cytology)
- Anatomic code (i.e. site) of specimen collection
- Date collected
- Date lab received
- Specimen accession number
- Date LHJ notified of result

**CRITICAL:**

If both smear and pathology/cytology are performed at the same time, and results differ (i.e. one is positive, one is negative), enter the result and other test information (e.g. type of exam, date collected) corresponding to the positive test. Remember, any positive supersedes a negative. If both tests are performed at the same time, and results are the same, both should be entered separately.

Subsequent results from later testing can be recorded by selecting the “Add New” link that appears adjacent to the most recent result on record.
Culture of tissue and other body fluids

If “Positive” or “Negative,” record the following:

- Anatomic code (i.e. site) of specimen collection
- Date collected
- Date lab received
- Specimen accession number
- Date LHJ notified of result
- Reporting laboratory type
- Reporting laboratory

Subsequent results from later testing can be recorded by selecting the “Add New” link that appears adjacent to the most recent result on record.

Nucleic Acid Amplification test (NAAT)

If “Positive” or “Negative,” or “Indeterminate,” specify further information:

- Specimen type (Sputum or Other)
- If specimen type is Other, the anatomic code (i.e. site) of specimen collection
- Date collected
- Date LHJ notified of result
- Reporting laboratory type
- Reporting laboratory
Subsequent results from later testing can be recorded by selecting the “Add New” link that appears adjacent to the most recent result on record.

<table>
<thead>
<tr>
<th>Isolate submitted for genotyping</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genotyping accession number</td>
<td></td>
</tr>
<tr>
<td>M. Bovis Status</td>
<td></td>
</tr>
</tbody>
</table>

**Isolate submitted for genotyping – DOH Field**

DOH will select “Yes,” “No,” or “Unknown.” (See CDC RVCT Manual page 158 for further details).

Additional windows will appear.

**The following additional questions will be grayed out to users.**

DOH TB Program is responsible for inputting the following information:

- Genotyping accession number
- M. Bovis Status

**Note:** Please contact the DOH TB Program with any questions about this or any other genotyping information about your culture-positive cases.

**Imaging**

<table>
<thead>
<tr>
<th>Imaging</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Initial/follow-up chest radiograph □</td>
</tr>
<tr>
<td>* Evidence of a cavity</td>
</tr>
<tr>
<td>* Evidence of Miliary TB</td>
</tr>
<tr>
<td>* Date chest radiograph done MM/DD/YYYY</td>
</tr>
</tbody>
</table>

**Initial Chest Radiograph (CXR)**

Dropdown options:

- Normal (including abnormal not consistent w/TB)
  - Record date chest radiograph done
- Abnormal (consistent w/TB)
  - Record evidence of cavity result
  - Record evidence of miliary TB result
  - Record date chest radiograph done
- Not done
- Unknown
Subsequent results from later CXRs can be recorded by selecting the “Add New” link that appears adjacent to the most recent imaging result on record.

Initial/follow-up chest CT scan or other chest imaging
Select from the following results:

- Normal (including abnormal not consistent w/TB)
  - Record date scanning/imaging done.
- Abnormal (consistent w/TB)
  - Record evidence of cavity result
  - Record evidence of miliary TB result
  - Record date scanning/imaging done
- Not done
- Unknown

Subsequent results from later CT imaging can be recorded by selecting the “Add New” link that appears adjacent to the most recent imaging result on record. This might be helpful if a follow-up chest radiograph was completed AND a CT scan.

Infectious period start date
If a date for “First symptom onset date” is reported, this field will autofill at three months prior to the first onset of symptoms. Otherwise, this date should be manually entered as three months prior to the date of TB disease diagnosis.
Comments

Comments and command buttons
Insert additional comments in this field, if needed. Click “Save” button to save your changes and return to the Event Summary screen. A “Cancel” and “Help” button are also available options.
Treatment Question Package

Treatment

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Type of outpatient health care provider</th>
<th>Other</th>
<th>Add New</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specify</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Current medication (excluding TB drugs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Current weight (lbs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weight in kilograms</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Type of outpatient health care provider**

If the patient is receiving TB care in an outpatient setting, indicate from the options below the type(s) of provider having primary responsibility for clinical decision-making. Refer to the [CDC RVCT Manual](#) (page 188) for definitions of provider types.

- Local/State Health Department (HD)
- Private outpatient
- IHS, Tribal HD, or Tribal Corporation
- Institutional/Correctional
- Inpatient care only
- Unknown
- Other (additional window appears to specify provider type)

Multiple provider types can be recorded by selecting the “Add New” link that appears next to the preceding selection.

**Current medication (excluding TB drugs)**

Excluding TB drugs, record any medications the patient takes routinely.

**Current weight (lbs)**

Add patient’s current weight in pounds (lbs). Weight (in lbs) will be converted and autofill “Weight in kilograms,” to provide conversions useful in drug dosing.
Drug Regimen

For each drug listed indicate if it was included in the initial drug regimen prescribed. Answer “Yes,” if the drug was initially prescribed and taken for at least 2 weeks. Also answer “Yes,” if the drug was initially prescribed but the duration of initial treatment cannot be determined. Answer “No,” if the drug is known to not be part of the initial regimen. Refer to the CDC RVCT Manual (page 155) for additional information.

Note: the reported drug regimen should only include anti-TB drugs prescribed to treat TB disease. Supplements such as B6 should not be reported under “Other” drugs).

CRITICAL:
If the patient began taking any of the drugs prescribed, “Date therapy started” for the overall regimen must be reported, regardless of start dates entered for any individual drug. Enter date the patient first began taking any TB drugs in the initial regimen.

For each of the drugs included in the initial regimen, record the following:

- Dosage
- Frequency
- Date started
- Date stopped
- Anticipated treatment duration
Drug Treatment Follow-Up

**Date therapy stopped**
Record the last date the patient stopped taking TB drugs prescribed. Please refer to the [CDC RVCT Manual](#) (page 179) for important details on how to select this date.

**Reason therapy stopped or never started**
Record this when the patient completes the prescribed treatment course, or if the case is closed otherwise (e.g. Lost). Select one of the options below. Also refer to the [CDC RVCT Manual](#) (page 182) for important additional details on how to select the most appropriate reason.

- Completed therapy (i.e. patient completed the prescribed course of therapy as recorded in the medical record by the clinician caring for the patient).
- Died (i.e. patient was alive at diagnosis, but died before the start or completion of therapy; or the patient was taking at least 2 anti-TB drugs prior to their death, though the case could not be verified or counted until after death).
  
  If “Died,” an additional window “Indicate cause of death” will appear. From the following choices, indicate whether the death was related to TB therapy or TB disease:
  
  - Related to TB disease
  - Related to TB therapy
  - Unrelated to TB disease
  - Unknown

- Lost (i.e. patient could not be located before the start, or completion, of therapy).
  
  **Note**: if patient has moved outside of the U.S. and cannot be located, record “Other” for reason therapy stopped or never started.
- Not TB (i.e. findings from a completed diagnostic evaluation could not support the diagnosis of TB disease).
- Patient chose to stop (i.e. patient refused to either initiate or complete therapy without provider’s consent).
- Provider decision – adverse treatment event (i.e. provider discontinued therapy due to adverse treatment event(s). **Note:** if patient died due to adverse event, record “Died” for reason therapy stopped or never started.
- Unknown (i.e. reason therapy stopped is not known).
- Other (i.e. reason therapy stopped is known, and not otherwise included in the above response choices). Specify reason in window that appears.

<table>
<thead>
<tr>
<th>Reason therapy extended &gt; 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was original treatment course altered due to drug resistance or adverse events?</td>
</tr>
<tr>
<td><em>(If altered due to adverse drug reactions, select type)</em></td>
</tr>
<tr>
<td><em>Data adverse drug reaction symptoms first experienced</em></td>
</tr>
</tbody>
</table>

### Reason therapy extended > 12 months

If the duration of therapy was extended beyond 12 months, record this when the patient completed the prescribed treatment course, or if the case is closed otherwise (e.g. Lost). Select one of the options below. Also refer to the [CDC RVCT Manual](https://www.cdc.gov/vip/rtc/rvct_manual.html) (page 186) for additional details.

- Rifampin resistance
- Adverse drug reaction
- Non-Adherence
- Failure
- Clinically indicated other reasons (i.e. other than adverse reaction)
- Other (additional window appears to specify)

Multiple reasons can be recorded by selecting the “Add New” link that appears next to the preceding selection.

### Was original treatment course altered due to drug resistance or adverse events?

If original treatment course was altered due to adverse drug reaction(s), select from the following to indicate adverse drug reactions experienced by the patient.

- Severe allergic reaction
- Blurred or altered vision
- Hepatic toxicity
- Central nervous system effects
- Peripheral neuropathy
- Severe gastrointestinal upset
- Gout
- Abnormal bleeding problems
- Severe drug interaction
- Other
Date adverse drug reaction symptoms first experienced
Record date the patient first experienced any of the adverse drug reactions reported.

Additional adverse drug reactions experienced by the patient can be recorded by selecting the “Add New” link that appears after each preceding selection.

<table>
<thead>
<tr>
<th>Directly observed therapy (DOT)</th>
<th>Yes (Completely directly observed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specify virtual observation method</td>
<td>Other</td>
</tr>
<tr>
<td>Number of weeks of DOT</td>
<td></td>
</tr>
</tbody>
</table>

**Directly observed therapy (DOT):**
Select from the following, the extent of DOT used during the course of treatment. Refer to the [CDC RVCT Manual](https://www.cdc.gov/vhf/rvct/manual.html) (page 191) for additional details on each selection.

- No ( Completely self-administered) — No doses were given under DOT.
- Yes (Completely directly observed) — All doses administered under DOT. This also applies if DOT was used to administer at least 5 doses in a 7 days per week regimen.
- Yes (Both directly observed and self-administered) — Select if a mixture of DOT and self-administered therapy counted toward completion, beyond what is described above.
- Unknown — it is not known whether any doses were given under DOT.

If DOT was used to any extent during treatment, answer the following:

**Specify virtual observation method:**
- Electronic
- Other (additional window appears to specify)

**Number of weeks of Directly Observed Therapy (DOT)**
Record the completed number of DOT weeks. See [CDC RVCT Manual](https://www.cdc.gov/vhf/rvct/manual.html) (page 192) for important details on counting DOT weeks.
IMPORTANT:
Report of initial drug susceptibility testing (DST) is currently restricted to recording results from conventional DST only (i.e. 1st-line DST, traditional culture DST, broth DST or plate methods). Do not report rapid DST test results (molecular beacon, molecular line probe assays, or other molecular tests).

Molecular DST is currently available only through CDC, being referred to as Molecular Detection of Drug Resistance (MDDR). This testing requires pre-approval by the WA DOH public health lab, after consultation with the DOH TB Program.

Initial drug susceptibility testing done?
If “Yes,” is selected, additional questions will appear.

Date FIRST isolate collected on which drug susceptibility testing (DST) was done.
Record the collection date of the first specimen on which initial DST was performed.

Note: if DST was performed on multiple isolates, select one of the following:

- The isolate associated with the primary site of disease.
- The isolate from the primary site of disease that yields the most information regarding DST results.
- The initial culture-positive isolate.
Refer to the [CDC RVCT Manual](https://www.cdc.gov/tb/publications/moricum/cdc-rvct-manual.pdf) (page 164) for important additional details.

**Specimen type**
Options are:
- Sputum
- Other
  - If specimen is other than sputum, specify anatomic site

**Date LHJ notified of initial susceptibility results**
Record date the LHJ accountable for TB case management was notified of initial drug susceptibility results.

**Result**
Record initial DST results for *each* drug listed, selecting from the following responses:
- Susceptible (select if isolate is *completely* susceptible to the given drug)
- Resistant (select if isolate is found to have *any* degree of resistance to the given drug, including partial resistance or resistance at a low drug concentration)
- Not done (select if known that initial DST was not performed for the given drug)
- Unknown (select if it is *not* known whether initial DST was performed, or results are unknown for a reason other than remaining pending).

If initial DST is performed for drug(s) other than those listed, enter the drug tested using “Other drug?” and report results as described above.

**Follow-up drug susceptibility testing (DST) done?**
If follow-up DST was performed, record testing and result details from the FINAL isolate on which DST was performed, as described above under “Initial drug susceptibility testing done?”

*Note:* to be considered as “follow-up” DST, isolate should be collected *at least 30 days after the isolate used in initial DST.* Refer to the [CDC RVCT Manual](https://www.cdc.gov/tb/publications/moricum/cdc-rvct-manual.pdf) (page 196) for important additional details.
## MDR (treatment details)

<table>
<thead>
<tr>
<th>MDR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Upon treatment completion, fill out this section if the patient was treated as an MDR TB case. Select Yes below for a case with confirmed or empirical drug resistance to at least isoniazid and rifampin. This DOES NOT include cases treated with second line medication due to side effects or contraindications.</strong></td>
</tr>
<tr>
<td><strong>Was the Patient Treated as an MDR TB Case (Regardless of DST Results)?</strong></td>
</tr>
<tr>
<td>History of treatment before current episode with second-line TB drugs for the treatment of TB disease (not LTBI)?</td>
</tr>
<tr>
<td>Date MDR TB therapy started for current episode</td>
</tr>
<tr>
<td><strong>Drugs ever used for MDR TB treatment, from MDR start date (select one option for each drug)</strong></td>
</tr>
<tr>
<td>^ indicates second- or third-line medication for purpose of US surveillance</td>
</tr>
<tr>
<td>Date injectable medication was stopped</td>
</tr>
<tr>
<td>Was surgery performed to treat MDR TB?</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>
**Was the Patient Treated as an MDR TB Case?**
Indicate if the patient was, or was not, treated for multi-drug resistant TB (MDR TB). Multi-drug resistant TB is defined as TB resistant to at least the first-line drugs Isoniazid and Rifampin.

If “Yes,” include the following additional details regarding the patient’s treatment course.

- **History of treatment before current episode with second-line TB drugs for the treatment of TB disease (not LTBI)?**
  Indicate if the patient has previously been treated with second-line TB drugs for the treatment of TB disease.

- **Date MDR TB therapy started for current episode**
  Enter date the patient first began taking TB medications prescribed for the treatment of MDR TB.

- **Drugs ever used for MDR TB treatment, from MDR start date (select one option for each drug)**
  For each of the drugs listed, indicate the duration the drug was taken over the current treatment course. Response options include:
    - Not used
    - Less than 1 month
    - 1 month or more

- **Date injectable medication was stopped**
  Enter the last date that injectable medication was administered.

- **Was surgery performed to treat MDR TB?**
  Indicate whether the patient’s treatment course included surgery.
    
    If “Yes,” enter the date that surgery was performed.
Side effects

For each of the possible side effects listed, indicate whether the patient did, or did not, experience the side effect during the course of treatment. Side effects of particular concern include the following:

- Depression
- Suicide attempt or ideation
- Cardiac abnormalities
- Hearing loss
- Tinnitus
- Vestibular Dysfunction
- Peripheral Neuropathy
- Renal Dysfunction
- Vision change/loss
- Liver toxicity
- Myalgia
- Arthralgia
- Other; specify side effects, and when they occurred
**Did patient move during therapy?**

This field is grayed-out, as this question is first asked on the “Demographics” question package under “Patient Location.” This information is repeated here as a reminder that the case may need follow-up with other jurisdictions.

**Comments**

![Comments](image)

**Comments and command buttons**

Insert additional comments in this field, if needed. Click “Save” button to save your changes and return to the **Event Summary** screen. A “Cancel” and “Help” button are also available options.

*Important note:* Comments entered here in the “Treatment” question package are copied into the “Comments” section of the “Report of Verified Case of Tuberculosis (CDC RVCT Form)” Wizard under “Follow up Report – 2,” and vice versa.
Additional Information Question Package

Additional Information

<table>
<thead>
<tr>
<th>Contact investigation start date</th>
<th>MM/DD/YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Insurance</td>
<td></td>
</tr>
<tr>
<td>Health Officer isolation order issued</td>
<td>Yes □ Add New</td>
</tr>
<tr>
<td>Isolation order issue date</td>
<td>MM/DD/YYYY</td>
</tr>
<tr>
<td>Quarantine station consultation?</td>
<td></td>
</tr>
<tr>
<td>Overseas CXR available?</td>
<td></td>
</tr>
</tbody>
</table>

**Contact investigation start date**
Enter the date any contact investigation was initiated.

**Type of insurance**
Select between the following:
- Employer
- Individual
- Medicare
- Medicaid
- VA/Military
- Uninsured

**Health Officer isolation order issued**
If “Yes,” an additional window appears to specify the date the isolation order was issued.

Multiple orders can be recorded
- Select the “Add New” link that appears after selecting “Yes” or “No.”

For more information, reference WAC 246-100-040, “... a local health officer may issue an emergency detention order causing a person or group of persons to be immediately detained for purposes of isolation or quarantine ....” See the [Washington Administrative Code (WACs)](https://app.egov.wa.gov/init/aca/WAC/) for more information.

**Quarantine station consultation?**
If “Yes,” a new window appears to specify the date the quarantine station was contacted.

**Overseas CXR available?**
This area is grayed-out. To change this field, refer to the same question in the “Demographics” question package.
Comments

LHJ close case
By selecting “Yes,” a workflow message is initiated that alerts the DOH TB Program to review the case for closing.

DOH close case
The DOH TB Program will determine if the case content is complete for CDC reporting. The program will reach out to the investigator if there are any further questions before the case can be closed.

Note: for reporting purposes, once a case is closed the information cannot be altered. A case can be reopened, however the DOH TB Program must be contacted to reopen the case.

Comments and command buttons
Insert additional comments in this field, if needed. Click “Save” button to save your changes and return to the Event Summary screen. A “Cancel” and “Help” button are also available.
Local Health Jurisdictions do not need to access this screen. This question package is for use of the DOH TB Program only and will be hidden in future versions of WDRS.

**Command buttons**

Insert additional comments in this field, if needed. Click “Save” button to save your changes and return to the Event Summary screen. A “Cancel” and “Help” button are also available options.
TB CONTACT EVENTS

Linking Contacts

First, go to the Event Summary screen of the source case record you have either found, if it already exists, or have newly created in WDRS.

**NOTE**: Remember to always search for an existing event or person, before creating a new event or person.

![Event Summary](#)

From the source case’s Event Summary screen, click “View” adjacent to “Linked Events/Contacts:”

![Linked Events - Winston The Dog - TB disease](#)

Any existing TB-related events (e.g. cases, contacts, infection) already linked to the source case will be displayed in the “Linked Events” line-list at the top of the screen.
This line-list can also be filtered by type of linked event, by selecting the appropriate event type (i.e. TB contact, TB disease, TB infection) from the drop-down list for “Disease:.” This line list can also be similarly filtered by “Status:” of the event (i.e. open, closed, deleted).

Below this line-list, a separate “Link Events” section allows you to either, (1) create a new TB contact event linked to the source case, or (2) link existing event(s) as contacts to the source case. **Note:** the default Operation is “Create Linked Event.” This can be changed accordingly whether you are linking a new or existing WDRS event.

![Link Events](image)

**FIRST,** search in WDRS for the person identified as a contact to the source case. Click on “Select Person…” to open a WDRS event search screen.

![Search Criteria](image)

Enter personal identifying information (e.g. first and last names, date of birth) into the “Search Criteria” that matches the person identified as a contact. **Note:** your search results will be as specific as the search criteria you provide.

**CRITICAL:**

When searching for a person in WDRS, it’s **very** important to avoid missing a match, due for example, to slight differences in spelling. If your search does not at first return any clear matches, make your search criteria less specific.

You can make your search criteria less specific, and “widen” your search, by using the **wildcard** function (e.g. using Br* to return all names beginning with “Br”) or search using **Soundex** which
matches words phonetically (i.e. by pronounced sound). For more detailed information on how to search most effectively in WDRS, please refer to the WDRS Reference Guide. If the person identified as a contact does not already exist in WDRS (i.e. is not found in “Search Results”), proceed with creating a new linked contact event as described in the following pages.

If the person identified as a contact does exist in WDRS (i.e. is found in “Search Results”), proceed with Linking existing WDRS event(s) to a source case in a later section.

Creating a new TB contact event, as a new person record, linked to the source case—*when an identified contact does not already exist in WDRS

![Link Events](image)

- For Operation:, select “Create Linked Event.”

**IMPORTANT:**
To ensure that linkages between events are fully and accurately described within the WDRS system, it is very important to select a value for each link descriptor detailed below (i.e. “Disease,” “Link Type,” and “Relationship”).

- For Disease:, select “TB contact.”
- For Link Type:, select the option that best describes the linkage, according to one of the aspects below. **Note:** the link type options below are a subset most relevant to TB, of all choices provided-for in WDRS.

<table>
<thead>
<tr>
<th>(1) Association of the linked event being created to the case, for example:</th>
<th>(2) Context of exposure, for example:</th>
<th>(3) Other reason for the linkage, for example:</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Contact</td>
<td>o Household contact</td>
<td>o Epi-linked</td>
</tr>
<tr>
<td>o Source</td>
<td>o Daycare/School/Work contact</td>
<td>o Disease progression</td>
</tr>
<tr>
<td>o Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For Relationship:, select the option that most accurately describes the interpersonal relationship of the contact to the source case. Choices most relevant to TB include:

- Extended Family
- Parent
- Guardian
- Child
- Foster Child
- Sibling
- Spouse
- Life Partner
- Co-worker
- Care Giver
- Housemate
- Other

After specifying the type and relationship describing the linkage, provide identifying information for the contact being linked to the source case, in the sections Demographics, Communication Information, and Contact Information. Enter information exactly how you would when creating a new WDRS event. After entering identifying information, scroll to the bottom of the screen, and click “Save.” Refer to the WDRS Reference Guide for specific instructions on how to create a new event in WDRS.

Now, the newly linked contact event will be displayed in the “Linked Events” line-list of the source case.

The source case also now appears in the “Linked Events” line-list of the newly linked TB contact.
Linking a new or existing TB contact event to a new TB infection or TB disease event — *when a contact is diagnosed with TB infection or TB disease

**IMPORTANT:**

When a TB contact is diagnosed with either TB infection or TB disease during an ongoing contact investigation or after, a new TB event corresponding to the diagnosis **must** be created, **and** linked back to the initial TB contact event.

**Note:** whenever an existing TB event develops into another TB condition (e.g. a TB contact is diagnosed, or TB infection progresses to TB disease), it is **highly recommended** to use a copy of the existing TB event to create an event corresponding to the new, other TB condition. Doing so will ensure data in the existing event is retained in the new TB event, and do not need to be re-entered.

To use a copy of a TB contact event to create another TB condition event, first return to the **Event Summary** screen of the TB contact event you newly created, or found during your initial search in WDRS.

![Event Summary](image)

Click “Copy Event.”
You will then first see a “Source Event,” section that displays much of the information found in the “Basic Information” section of the **Event Summary** screen. Below the “Source Event” section you will see a “Target Event” section.

- **For Copy Mode:** leave the default value “Copy to new event,” as is.
- **For Disease:**
  - Select “TB infection,” if diagnosed with TB infection
  - Select “TB disease,” if diagnosed with TB disease
- **For Status:** the default value is “Open.”
  - Select “Closed,” if the event will no longer be actively managed, and all requirements for closing the event are completed.

Adjacent to “Copy Question Packages,” select by question package all data you want copied to the new event. **Note:** to ensure all question package data contained in the existing TB event is copied to the new event, select all question packages. Existing data will be copied only for those fields that are common to each event.
Adjacent to “Copy Fields,” you can also select additional information to be copied to the new event. **Note: always** include “Copy event links” in your selection, to ensure any other existing linkage(s) to other TB events are also copied to the new event.

- For Link to Source as:, select “Contact.”

Click “Save.”

![Event Summary](image)

An **Event Summary** screen will appear for the new TB infection event created from a copy of the TB contact event.

![Linked Events](image)

Note that events linked to the TB contact event have been retained in the TB infection event created.
Linking existing WDRS event(s) to a source case

The need to link existing WDRS events to a source case might occur, if for example, a contact linked to the case has been entered previously as a separate event in the current investigation or a previous investigation.

**IMPORTANT:**
During a current investigation, it is *highly recommended* that known contacts are first entered in WDRS by way of creating a new TB contact event linked to the source case — not entered as separate unlinked events. Doing so will save you from having to link the TB contact event(s) to the source case later.

However, if it is necessary to link an existing WDRS event to a source case, start from the source case’s Event Summary screen. Click “View” adjacent to “Linked Events/Contacts:” as described above, which will open to the “Link Events” section.

**Note:** The default choice for “Operation:” will be “Create Linked Event.” You will need to select “Link to Existing Event,” as described below.

![Link Events](image)

- For Operation:, select “Link to Existing Event.”
  **Note:** because you are linking to an existing event that has already been assigned a disease condition, “Disease” is omitted as a descriptor selection.
- For Link Type:, select the option that best describes the linkage.
- For Relationship:, select the option that most accurately describes the interpersonal relationship of the contact to the source case.
Click on “Select Event…” to open a WDRS event search screen. From the WDRS search screen proceed with entering search criteria and selecting the appropriate WDRS event as outlined above when first searching for a person in WDRS.

From events found in your search, highlight the correct WDRS event record, and click “Select.” All identifying information from the selected event will autofill the “Demographics,” “Communication Information,” and “Contact Information” sections. Scroll farther down below the “Contact Information” section, and click “Save.”

Now, the newly linked TB contact event will be displayed in the “Linked Events” line-list of the source case.
**CRITICAL** — when linking another diagnosed case of TB disease to the current case of TB disease in WDRS using “Link Events,” you must also link the two cases by entering the other diagnosed case (e.g. Wilma Bambam Mama Dog) as a “Linking case number” in the Administrative question package of the current case (e.g. Winston The Dog). Please refer to [Linking case numbers](#) above for important additional information and guidance regarding linking case numbers.
Disease Progression—when TB infection progresses to TB disease

Disease progression may be observed when you are conducting an initial WDRS person search prior to creating a new TB disease event, and that person matches to an earlier, existing TB infection event. In this scenario, a new WDRS TB disease event should be created from the existing TB infection event. Doing so will ensure that data existing in the TB infection record is retained in the new TB disease event.

The steps you take to record disease progression from TB infection to TB disease are similar in many ways to recording when a TB contact is diagnosed with TB infection or TB disease. Namely, that you will start by using a copy of the existing TB infection event to create a new TB disease event.

Start from the search results screen, clicking once on the existing TB infection event you found corresponding to the person currently diagnosed with TB disease. Click “Select,” to open to the Event Summary screen of the TB infection event selected.
Click “Copy Event,” and then scroll down to the “Target Event” section that appears.

- For Copy Mode:, leave the default value “Copy to new event,” as is.
- For Disease:, select “TB disease.”
- For Status:, leave the default value “Open,” as is.
- For Link to Source as:, select “Disease Progression.”

Adjacent to “Copy Question Packages,” select by question package all data you want copied to the new event. **Note:** to ensure all question package data contained in the existing TB infection event is copied to the new TB disease event, select all question packages. Existing data will be copied only for those fields that are common to each event’s question packages.

Adjacent to “Copy Fields,” you can also select additional information to be copied to the new TB disease event. **Note: always** include “Copy event links” in your selection, to ensure any other existing linkages to other TB events are also copied to the new event.

Clicking “Save” will open to the Event Summary screen of the new TB disease event.
From the **Event Summary** screen of the TB disease event created, clicking “View” adjacent to “Linked Events/Contacts:” will show that the TB infection event is automatically added to the list of events linked to this TB disease event.
Similarly, this TB disease event is also added to the events linked to the initial TB infection event.
The TB Contact Event and Question Packages

Returning to the “Linked Events” line-list for a source case, clicking on the hyperlink for one of any linked TB contact event(s) will open the **Event Summary** screen for that TB contact.

![Event Summary Screen](image)

Just as for TB disease events, the **Event Summary** screen includes an **Event Data** tab with a series of **Question Packages** to add information about the TB contact event record including: **Administrative, Demographics, Risk, Diagnostics and Evaluation, Treatment, and Additional Information**. Also as for TB disease events, in each question package any question marked by an asterisk (*) indicates a required reporting field. Until each of these fields is complete, the status in each question package will remain “**Incomplete**.”
Please note: As you enter data, keep in mind that the WDRS system will automatically time-out after 20 minutes of inactivity. Be sure to save the data you input in each question package by either clicking on the “Save & Stay” button, or the “Save” button which returns you to the Event Summary screen.

The TB Contact Wizard

The “TB Contact Wizard” contains all fields essential for contact investigation, case management, and reporting. Because of this, the “TB Contact Wizard” is a particularly useful tool that can confidently be used as an alternative to individual question packages for investigation, case management, and reporting of a TB contact event.

Exceptions to the above—of data that can only be entered and viewed in a WDRS question package—include important characteristics of the source case (i.e. smear result, CXR, disease site, and drug susceptibilities), along with select demographics (i.e. sex at birth). These exceptions will be highlighted and explained within the detailed review of the “TB Contact Wizard” to follow.

In addition, a TB contact event record shares many data fields with a TB disease event record, along with identical corresponding functions and steps to be taken. In the instructions to follow on management of a TB contact event record, when this is the case, hyperlinks will redirect you to corresponding instructions preceding in this manual.
The “TB Contact Wizard” tool is accessed by clicking in the “Wizards” window located at the bottom of the Event Data tab of the Event Summary screen, selecting the wizard tool, and clicking “View Wizard.”

Select reporting address
Please refer to preceding instructions on selecting reporting address. Selecting an official address will populate the field for “Accountable County” at the top of the “TB Contact Wizard.”

**IMPORTANT:**
If the person has changed their residence, for example from first being identified during an earlier contact investigation, it is important to add this new address into the person record connected with this TB contact event. Refer to preceding instructions on editing or adding an address for further detailed instructions.
**Investigator**
Please refer to preceding instructions on selecting an investigator.

**Date LHJ notified DOH**
This is the date your LHJ first created the TB contact event in WDRS. This date defaults to the initial create date of the TB contact record, but can be changed manually.

**Contact investigation start date**
Enter the date when the first contact was identified in relation to the current contact investigation.

**Date contact identified**
Enter the date when this particular contact was identified.

**Date contact interviewed**
Enter the date when this particular contact was interviewed. If the contact was interviewed on more than one occasion, enter the date of the first encounter.

**Date of last exposure**
Enter the date of the contact’s last day of exposure to the source case during the source case’s period of infectiousness.

**Contact investigation complete date**
Enter the date efforts were concluded regarding information gathering, evaluation and follow-up related to this and any other contacts identified in the corresponding contact investigation.

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### Case Numbers

<table>
<thead>
<tr>
<th>Case Numbers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>State contact number</td>
<td>2020WACon200005</td>
</tr>
<tr>
<td>County contact number</td>
<td></td>
</tr>
<tr>
<td>^ Linking case number</td>
<td></td>
</tr>
</tbody>
</table>

*Enter the source case State Case Number in the Linking Case Number field above, or enter jurisdiction/descriptor (e.g. California, Airline) if source case was not in WA.*

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**State Contact Number**
This number uniquely identifies the TB contact event for the DOH TB Program, and is automatically assigned when the TB contact event is first created in WDRS.
**County Contact Number**
This field is available to LHJs for assigning their own unique identifier to TB contacts.

**Linking Case Number**
If the source case was counted and or managed in Washington state, enter the state case number assigned to the source case. Otherwise, enter clear descriptor(s) of the source case’s jurisdiction and or context of the investigation.

**Demographics**

<table>
<thead>
<tr>
<th><strong>Country of birth</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred language</td>
<td></td>
</tr>
<tr>
<td>Interpreter needed?</td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>Did contact move during investigation?</td>
<td></td>
</tr>
<tr>
<td>Birth Date</td>
<td>01/01/2003</td>
</tr>
<tr>
<td>Age at date LHJ notified DOH</td>
<td>17</td>
</tr>
</tbody>
</table>

Please refer to the preceding section of instructions on country of birth and accompanying demographic information.

**Age at date LHJ notified DOH**
This field is autocalculated from the person’s recorded date of birth, and the date the TB contact event was created in WDRS.

**NOTE**: Within the WDRS event record of a TB contact, certain supplemental demographic information is recorded only within the Demographics question package (i.e. “Sex at birth”). The following is a review of this field.

**Sex at birth**
This field is autofilled from the value assigned to “Sex assigned at birth” in the Person record.
Parent/Legal Guardian

<table>
<thead>
<tr>
<th>Parent/legal guardian phone number</th>
</tr>
</thead>
</table>

Parent/legal guardian phone number
If this person is a minor, enter the primary phone number of the parent(s) or guardian(s) principally responsible for their care.

Risk History

<table>
<thead>
<tr>
<th>Risk History</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of BCG</td>
</tr>
<tr>
<td>Previous exposure to TB before this incident</td>
</tr>
<tr>
<td>* Does patient have previous history of TB disease?</td>
</tr>
<tr>
<td>Does patient have previous history of TB infection?</td>
</tr>
</tbody>
</table>

Please refer to the preceding section of instructions on risk history.

Place exposed to TB
Select one option that best describes the setting or context of exposure to TB disease.

Note: if “Other congregate settings” or “Other close contact” is selected, an additional field will appear to further specify.
Priority of contact
Assign a level of priority for follow-up of this contact with consideration of clinical characteristics of the source case, extent of exposure, characteristics of the contact, and aspects of the overall contact investigation. Below are select, suggested criteria on assigning priority to contacts when a source case is most likely to be infectious, based on guidance from the CDC. Please refer to CDC Guidelines for the Investigation of Contacts (page 11-15) for additional important details.

*When the source case presents with pulmonary, laryngeal or pleural site(s) of disease AND; shows evidence of cavitary lesion on chest radiograph, OR is sputum smear positive for AFB (acid-fast bacilli), AND:

- **High** priority contact; when *any* of the following criteria are met:
  - Is a household contact
  - Is < 5 years of age
  - Experiences one or more medical risk factors that suppress immune system functioning (e.g. diabetes, cancer, HIV)
  - Exposure occurred during a medical procedure (i.e. bronchoscopy, sputum induction, or autopsy)
  - Exposure occurred in a congregate setting
  - Exposure exceeded duration and environmental limits for assigning high priority, as set by the accountable jurisdiction

- **Medium** priority contact; when *none* of the above, but *any* of the following, criteria are met:
  - Is 5 to 15 years of age
  - Exposure exceeded duration and environmental limits for assigning medium priority, as set by the accountable jurisdiction

- **Low** priority contact:
  - Does not meet any of the above criteria corresponding to high, or medium priority.
**NOTE**: Within the WDRS event record of a TB contact, certain diagnostic information regarding the source case TB disease event, essential to assigning priority of contact, is recorded *only* within the Risk question package. The following is a review of these fields, along with guidance on data entry.

**Risk Question Package**

**Exposure**

<table>
<thead>
<tr>
<th>Index smear result</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Index chest radiograph</td>
<td>Abnormal (consistent with TB)</td>
</tr>
<tr>
<td>Evidence of cavity</td>
<td></td>
</tr>
</tbody>
</table>

**Index (i.e. Source case) [sputum] smear result**

Selections include:
- Smear +; any positive grade reported, including “rare”
- Smear -; no AFB seen
- Suspect; sputum smear results remain pending

**Index (i.e. Source case) chest radiograph**

Report on chest radiograph, or other imaging (e.g. CT scan) if radiograph is not done.
Selections include:
- Normal (including abnormal not consistent w/TB)
- Abnormal (consistent with TB)

- **Evidence of cavity**
  - When “Abnormal (consistent with TB),” indicate “Yes” or “No” whether evidence of cavity was found

**Index (i.e. Source case) drug resistance**

From initial drug susceptibility testing (DST) results, report any and all drugs the source’s isolate was found (at any level) resistant to. If no resistance was reported, select “None – pansensitive.”

**Index (i.e. Source case) TB site (select all that apply)**

Indicate all site(s) of TB disease. If selecting “Other,” also select the specific anatomic site of disease from the dropdown list in the additional field that appears.
## TB Contact Screening

<table>
<thead>
<tr>
<th>* Screening status</th>
<th>Not initiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Why wasn't the screening completed?</td>
<td>Prior positive, already on or completed treatment</td>
</tr>
</tbody>
</table>

### Screening status

Indicate the current status of contact screening. Selections include:

- Screening completed
- Not initiated
- Initiated by not completed

If “Not initiated” or “Initiated but not completed” is selected, the following additional field will appear:

**Why wasn’t the screening completed?**

Selections include:

- Prior positive, already on or completed treatment
- Deceased
- Lost to follow-up
- Moved
- Could not locate
- Previous TB case
- Uncooperative/refused
If “Initiated but not completed” or “Screening completed” is selected, the following additional fields will appear:

**TST Result**

Selections include:
- Positive
- Negative
- Indeterminate
- Not done
- Unknown

Once a selection is made the “Add New” link appears to enter additional tests.

If “Positive,” “Negative,” or “Indeterminate,” enter details in the following additional fields that will appear:

- **mm**
  Enter millimeters of induration

- **Date TST placed**
  Enter date this TST was placed
**Documentation**
Indicate whether this test and corresponding results are documented

**Testing round**
Indicate which round of testing these results correspond to.
Selections include:
- Prior
- First
- Second
- Greater than two (inconclusive/other results)

**IGRA Result**
Selections include:
- Positive
- Negative
- Indeterminate
- Not done
- Unknown

Once a selection is made the “Add New” link appears to enter additional tests.

If “Positive,” “Negative,” or “Indeterminate,” enter details in the following additional fields that will appear:

**Date**
Enter date the specimen was collected

**Documentation**
Indicate whether this test and corresponding results are documented

**Testing round**
Indicate which round of testing these results correspond to
Symptom check

Indicate whether the person has been evaluated for symptoms of TB disease. Once a selection is made the “Add New” link appears to enter additional symptom checks.

<table>
<thead>
<tr>
<th>Symptom check</th>
<th>Yes</th>
<th>Add New</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testing round</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>□</td>
<td>Appetite loss</td>
</tr>
<tr>
<td></td>
<td>□</td>
<td>Chest pain</td>
</tr>
<tr>
<td></td>
<td>□</td>
<td>Cough</td>
</tr>
<tr>
<td></td>
<td>□</td>
<td>Hemoptysis</td>
</tr>
<tr>
<td></td>
<td>□</td>
<td>Fatigue</td>
</tr>
<tr>
<td></td>
<td>□</td>
<td>Fever</td>
</tr>
<tr>
<td></td>
<td>□</td>
<td>Weight loss</td>
</tr>
<tr>
<td></td>
<td>□</td>
<td>Night sweats</td>
</tr>
</tbody>
</table>

If “Yes,” enter details in the following additional fields that will appear:

Date
Enter date the symptom check was performed

Testing round
Indicate which round of testing the symptom check corresponds to

Symptoms
Indicate which symptom(s) were reported at the given symptom check.

Note: if none of the symptoms shown were reported, make sure to select “No.”
Selections include:

- No
- Appetite loss
- Chest pain
- Cough
- Hemoptysis
- Fatigue
- Fever
- Weight loss
- Night sweats
Follow-up testing due on or after
Indicate the date follow-up (e.g. Second round) testing is due.

Note: Follow-up testing should be done no sooner than eight weeks from the last date of exposure to the source case.

Chest imaging done?
Select “Yes” or “No” to indicate that chest imaging has, or has not, been performed:
Once a selection is made the “Add New” link appears to enter additional imaging.

If “Yes,” enter details in the following additional fields that will appear:

Date scanning/imaging done
Enter date chest imaging was performed

Results
Indicate the overall impression given of the imaging results.
Selections include:
- Normal (including abnormal not consistent w/TB)
- Abnormal (consistent with TB)

Disposition
Indicate the overall disposition from screening and evaluation of the contact
Selections include:
- Not infected
- Infected
- TB disease
- Prior or coincidental TB
- Lost to follow-up
**IMPORTANT:**

Whenever a TB contact is diagnosed with either TB infection or TB disease, the TB contact event must be copied, and linked, to a new TB event corresponding to the diagnosis. See when a contact is diagnosed with TB infection or TB disease above for further details and instruction.

### Treatment

<table>
<thead>
<tr>
<th>Treatment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Window treatment offered</td>
<td>Yes</td>
</tr>
<tr>
<td>Treatment type</td>
<td></td>
</tr>
</tbody>
</table>

**Window treatment offered**

Select “Yes,” “No,” or “Unknown” to indicate if window prophylaxis treatment was offered. If “Yes,” the following field will appear to add further details.

**Treatment type**

Selections include:

- Window prophlaxis
- Declined
- Not done

**IMPORTANT:**

If the contact has been diagnosed with latent infection, important details on treatment and treatment disposition are recorded in the Treatment question package of the new TB infection event to be linked to this TB contact event.
**IMPORTANT:**
Data on final disposition regarding the “Reason therapy stopped or never started” are *essential* to monitoring success in contact investigation, for our state and your LHJ. *Please* take time to record this information accurately.

**Reason therapy stopped or never started**
Select the one option that most accurately indicates the reason therapy was stopped, or never started. Selections include:

- Completed therapy
- Declined
- Developed Active TB
- Died
- Lost
- Moved, follow-up unknown
- Patient chose to stop
- Prior adequate treatment
- Provider decision - adverse treatment event
- Provider decision – other
- Unknown
- Other; specify details

**Additional Information**

| Type of Insurance |  
|-------------------|---|
| Quarantine station consultation? | Yes |
| Date quarantine station contacted | MM/DD/YYYY |

* LHJ close case

| Comments |  
|----------|---|

* Indicates required field

**Type of insurance**
Select between the following:

- Employer
- Individual
- Medicare
- Medicaid
- VA/Military
- Uninsured
Quarantine station consultation?
If “Yes,” a new window appears to specify the date the quarantine station was contacted.

LHJ close case
By selecting “Yes,” a workflow message alerts the DOH TB Program to review the contact event for closing.

Comments and command buttons
Insert additional comments in this field, if needed. Click “Save” button to save your changes and return to the Event Summary screen. A “Cancel” and “Help” button are also available.