

Treatment Episode Data Set

Treatment episode data must be submitted for all individuals who receive substance use disorder and/or problem gambling treatment. The Client file must already exist in the IBHRS before Treatment Episode data can be submitted.

Treatment Episode data should be updated after any record in the Provider Treatment Episode (e.g. Care Status, Diagnosis, and Performance Outcome Measure) needs to be added, changed, or removed.

Profile

First Contact Date*			
Concerned Person*	<input type="checkbox"/> Yes	Referral Source*	
	<input type="checkbox"/> No	<i>See vocabulary key for all Referral Source Types</i>	
Evaluator Allowed to Contact Client*	<input type="checkbox"/> Yes	Scheduled Admission Date*	
	<input type="checkbox"/> No		
Intravenous Substance Use in Past 30 Days*	<input type="checkbox"/> Yes	Pregnant at First Contact Date*	<input type="checkbox"/> Yes
	<input type="checkbox"/> No		<input type="checkbox"/> No
	<input type="checkbox"/> NA		<input type="checkbox"/> NA
Open Date*		Closed Date	

Provider

IBHRS will default to your Provider Agency. If it does not, you can search for your Provider Agency in the Data Entry Screens.

Provider Client

Within the IBHRS Data Entry Screens you will be required to search for the Client associated with each Treatment Episode.

Special Initiative

During a Treatment Episode, no two Special Initiative records with the same Type Code may have overlapping dates. The Start Date for a Special Initiative must be greater than or equal to the Open Date of the associated Treatment Episode. If provided, the End Date for a Special Initiative must be less than or equal to the Closed Date, if there is a Closed Date.

Special Initiative Type	<input type="checkbox"/> Women and Children	Start Date
<i>Only applicable if associated with a corresponding Provider Contract Type</i>	<input type="checkbox"/> State Opioid Response (SOR)	
End Date	Children in Care with Client Count	
	<i>Required if Special Initiative Type is Women and Children</i>	

Care Status

There can only be one Admission Care Status for each program area within a Treatment Episode. Subsequent Care Statuses should have the Transfer or Discharge type.

Profile

Status*		<i>If the Care Status has a Status Code value of Pre-admission, only the Status Date and Status Code should be supplied for this Care Status. No other fields are required.</i>	
		<input type="checkbox"/> Pre-Admission	<input type="checkbox"/> Admission
		<input type="checkbox"/> Transfer	<input type="checkbox"/> Discharge
Status Date*	Program Area	<input type="checkbox"/> Substance Use Disorder Treatment <input type="checkbox"/> Gambling treatment	
In Care for Mental Health Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prior Substance Use Episode Known	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Required if Care Status Code is Admission</i>	<input type="checkbox"/> Refused	<i>Required if Care Status Type is Admission</i>	<input type="checkbox"/> Refused
Prior Substance Use Episode Count	<i>Required if Known is Yes</i>	Prior Gambling Episode Known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
Prior Gambling Episode Count	<i>Required if Known is Yes</i>	Prior Mental Health Episode Known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
Prior Mental Health Episode Count	<i>Required if Known is Yes</i>	Concerned Person Involved	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<i>Only report when Care Status Code is Discharge</i>	
Discharge Reason <i>Only report when Care Status Code is Transfer or Discharge</i>	<input type="checkbox"/> Treatment completed	<input type="checkbox"/> Dropped out of treatment	
	<input type="checkbox"/> Terminated by facility	<input type="checkbox"/> Death	
	<input type="checkbox"/> Incarcerated or released by or to courts	<input type="checkbox"/> Transferred to another treatment program or facility	
	<input type="checkbox"/> Transferred to another treatment program or facility but client is no show	<input type="checkbox"/> Transferred to another treatment program or facility that is not in the SSA or SMHA reporting system	
	<input type="checkbox"/> Discharged from the State Hospital to an acute medical facility for medical purposes	<input type="checkbox"/> Other	

Provider Site

Within the IBHRS Data Entry Screens you will be required to search for the Provider Site associated with each Care Status.

ASAM

ASAM Level of Care

See vocabulary key for all ASAM Levels of Care.

Recommended Level of Care

See vocabulary key for all Recommended Levels of Care

Required for all Care Status Types except Pre-Admission.

Required for Care Status Type of Admission

Discharge Care Status ASAM Level of Care should be the same as the Predecessor Care Status ASAM Level of Care.

Clinical Override Reason <i>Required if Recommended Level of Care is different from ASAM Level of Care</i>	<input type="checkbox"/> Lack of insurance benefits	<input type="checkbox"/> Managed care refusal
	<input type="checkbox"/> Clinical judgment	<input type="checkbox"/> Patient opinion
	<input type="checkbox"/> Level of care not available	<input type="checkbox"/> Legal issues
	<input type="checkbox"/> N/A	<input type="checkbox"/> Other

Predecessor Care Status

If a Care Status has a Status of Transfer or Discharge, then the Predecessor Source Record Identifier must exist and reference a Care Status within the same Provider Treatment Episode and Program Area. The referenced Care Status must have a Status of Transfer or Admission.

Within the IBHRS Data Entry Screens you can search for the Predecessor Care Status.

Performance Outcome Measure

Each Care Status must have at least one associated Performance Outcome Measure record.

Profile

Pregnant Last 12 Months* Yes No Refused

Performance Outcome Measure Date*	Days Substance Used in Past 30 Days* <i>Required if Care Status type is Substance Use</i>
-----------------------------------	--

Days Gambled in Past 30 Days* <i>Required if Care Status type is Gambling</i>	Pregnant*	<input type="checkbox"/> Yes
		<input type="checkbox"/> No
		<input type="checkbox"/> Not Applicable

Pre-Screening

Required for Pre-Admission Care Status unless it is for a Concerned Person.

Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

Gambling in Past 12 Months Number*		Binge Drinking in Past 12 Months Number*	
Illicit Drugs or Prescriptions in Past 12 Months Number*		Mental Health Concern in Past 12 Months*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis Risk <i>Required when Provider Contract Type requires screening for TB</i>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Refused	Suicide Risk Screening <i>Required when Provider Contract Type requires screening for Suicide</i>	<input type="checkbox"/> Suicide Risk Indicated <input type="checkbox"/> Suicide Risk Not Indicated <input type="checkbox"/> Refused

Client Demographic

Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

Military Status*	<input type="checkbox"/> Veteran <input type="checkbox"/> Not a Veteran <input type="checkbox"/> Refused	Marital Status*	<input type="checkbox"/> Never Married <input type="checkbox"/> Now Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Refused
Residence County*			

Financial and Household

Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

Primary Income Source*	<input type="checkbox"/> Wages/Salary <input type="checkbox"/> Public assistance <input type="checkbox"/> Retirement/ Pension <input type="checkbox"/> Disability <input type="checkbox"/> None <input type="checkbox"/> Other <input type="checkbox"/> Refused	Health Insurance*	<input type="checkbox"/> Private insurance <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Health Maintenance Organization (HMO) <input type="checkbox"/> Other (e.g. TRICARE) <input type="checkbox"/> None <input type="checkbox"/> Refused
Living Arrangement* <i>See vocabulary key for all Living Arrangements.</i>	Monthly Household Income Known*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	
Monthly Household Income Amount <i>Required if Known is yes</i>	Others Helped Financially in Past 6 Months*	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Ever Declared Bankruptcy*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Debt Amount*
<i>Required if Program Area is Gambling</i>		
Money Lost Gambling in Past 30 Days*	Children 17 and Under Known*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
<i>Required if Program Area is Gambling</i>		
Children 17 and Under Count*	Custody of Children 17 and Under Count <i>Required if Known is Yes</i>	

Education and Employment

Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

Education Grade Level*	Employment Status*
<i>See vocabulary key for all Grade Levels</i>	<i>See vocabulary key for all Employment Statuses</i>

Legal

Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

Arrests in Past 30 Days Known*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	# Arrests in Past 30 Days <i>Required if Known is Yes</i>
Arrests Related to Gambling in Past 30 Days	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	Arrests Related to Substance Use in Past 30 Days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
<i>Required if Known is Yes and Program Area is Gambling</i>		<i>Required if Known is Yes and Program Area is Substance Use</i>

Overdose

Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

Lifetime Overdoses Known*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	# Lifetime Overdoses <i>Required if Known is Yes</i>
# Lifetime Treated Overdoses <i>Required if # Lifetime Overdoses >0</i>	Past 30 Days Overdose*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused

Suicide Risk

Suicide Risk should be provided if Pre-Screening results were positive for Suicide Risk

Suicide Risk Assessment Completed*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	Suicide Risk Assessment Result*	<input type="checkbox"/> Imminent Risk <input type="checkbox"/> Non-Imminent Risk
Suicide Safety Plan Developed or Reviewed*	<input type="checkbox"/> Yes, plan was developed <input type="checkbox"/> Yes, existing plan was reviewed <input type="checkbox"/> No <input type="checkbox"/> Refused	Transfer to Hospital Due to Suicide Risk*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused

Screening Results

Positive Pre-Screenings must have a Screening Result.

Program Area Code*	<input type="checkbox"/> Substance Use Disorder Treatment <input type="checkbox"/> Gambling Treatment	Recommended ASAM Level of Care* <i>See vocabulary key for all Recommended ASAM Levels of Care</i>
Intention to Follow Recommendation*	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Program Area Code*	<input type="checkbox"/> Substance Use Disorder Treatment <input type="checkbox"/> Gambling Treatment	Recommended ASAM Level of Care* <i>See vocabulary key for all Recommended ASAM Levels of Care</i>
Intention to Follow Recommendation*	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Overdose – Overdose Events in Past 30 Days

Required if “Past 30 Days Overdose” is Yes

Substance Type*	<i>See vocabulary key for all Substance Types</i>	
Was Treated*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	Treatment Location Type <i>Required if Was Treated is Yes</i> <i>See vocabulary key for all Treatment Locations</i>

Substance Type

See vocabulary key for all Substance Types

Was Treated

- Yes
- No
- Refused

Treatment Location Type

Required if Was Treated is Yes

See vocabulary key for all Treatment Locations

Substance Type

See vocabulary key for all Substance Types

Was Treated

- Yes
- No
- Refused

Treatment Location Type

Required if Was Treated is Yes

See vocabulary key for all Treatment Locations

Recovery Groups

Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

Recovery Group Type*

- Substance use self-help group
Required if Program Area is Substance Use
- Gambling self-help group
Required if Program Area is Gambling
- Other

Days Attended in Past 30 Days*

Recovery Group Type

- Substance use self-help group
Required if Program Area is Substance Use
- Gambling self-help group
Required if Program Area is Gambling
- Other

Days Attended in Past 30 Days

Recovery Group Type

- Substance use self-help group
Required if Program Area is Substance Use
- Gambling self-help group
Required if Program Area is Gambling
- Other

Days Attended in Past 30 Days

Substances Used

If the Provider Treatment Episode indicates Yes for the Intravenous Substance Use In Past 30 Days Code field, then there should be at least one Substance Used with a Route of Administration Code of Injection where the Performance Outcome Measure Date is greater than or equal to the Open Date and less than 30 days after the Provider Treatment Episode Open Date.

Report all substances used at the time of the Performance Outcome Measure. If using only one substance, report the substance used under "Substance Used #1).

Substance Used #1

Required if Care Status Program Area is Substance Use

Substance Type*
See vocabulary key for all Substance Types

Detailed Type* See vocabulary key for all Detailed Substance Types	Substance Rank	1
	Number*	

Route of Administration*	<input type="checkbox"/> Oral <input type="checkbox"/> Smoking <input type="checkbox"/> Inhalation <input type="checkbox"/> Injection <input type="checkbox"/> Other <input type="checkbox"/> Refused	Past 30 Days Frequency*	<input type="checkbox"/> None in the past month <input type="checkbox"/> 1-3 days in the past month <input type="checkbox"/> 1-2 days in the past week <input type="checkbox"/> 3-6 days in the past week <input type="checkbox"/> Daily <input type="checkbox"/> Refused
--------------------------	--	-------------------------	--

Age of First Use*

Additional Substance Used (If Applicable)

Substance Type
See vocabulary key for all Substance Types

Detailed Type See vocabulary key for all Detailed Substance Types	Substance Rank	2
	Number	

Route of Administration	<input type="checkbox"/> Oral <input type="checkbox"/> Smoking <input type="checkbox"/> Inhalation <input type="checkbox"/> Injection <input type="checkbox"/> Other <input type="checkbox"/> Refused	Past 30 Days Frequency	<input type="checkbox"/> None in the past month <input type="checkbox"/> 1-3 days in the past month <input type="checkbox"/> 1-2 days in the past week <input type="checkbox"/> 3-6 days in the past week <input type="checkbox"/> Daily <input type="checkbox"/> Refused
-------------------------	--	------------------------	--

Age of First Use Number

Additional Substance Used (If Applicable)

Substance Type

See vocabulary key for all Substance Types

Detailed Type

See vocabulary key for all Detailed Substance Types

Substance Rank 3
Number

Route of Administration	<input type="checkbox"/> Oral <input type="checkbox"/> Smoking <input type="checkbox"/> Inhalation <input type="checkbox"/> Injection <input type="checkbox"/> Other <input type="checkbox"/> Refused	Past 30 Days Frequency	<input type="checkbox"/> None in the past month <input type="checkbox"/> 1-3 days in the past month <input type="checkbox"/> 1-2 days in the past week <input type="checkbox"/> 3-6 days in the past week <input type="checkbox"/> Daily <input type="checkbox"/> Refused
-------------------------	--	------------------------	--

Age of First Use

Mental Health Symptoms

Mental Health Symptoms should be provided if Pre-Screening results were positive for Mental Health Concern

Each table should apply to only one symptom. For any additional symptoms, please complete an additional table.

Mental Health Symptom*	<input type="checkbox"/> Experienced serious depression <input type="checkbox"/> Anxiety/Tension <input type="checkbox"/> Hallucinations <input type="checkbox"/> Attempted suicide <input type="checkbox"/> Trouble controlling violent behavior <input type="checkbox"/> Trouble understanding/ concentrating or remembering <input type="checkbox"/> Been prescribed medication for psychological/emotional problems <input type="checkbox"/> Refused	Symptom in Past 30 Days Number*
------------------------	---	---------------------------------

Bothered by Symptom in Past 30 Days*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	Receiving Help with Symptom*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
--------------------------------------	---	------------------------------	---

Interested in Receiving Help with Symptom <i>Required if Receiving Help is No</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
--	---

Mental Health Symptom*	<input type="checkbox"/> Experienced serious depression <input type="checkbox"/> Anxiety/Tension <input type="checkbox"/> Hallucinations <input type="checkbox"/> Attempted suicide <input type="checkbox"/> Trouble controlling violent behavior <input type="checkbox"/> Trouble understanding/ concentrating or remembering <input type="checkbox"/> Been prescribed medication for psychological/emotional problems <input type="checkbox"/> Refused	Symptom in Past 30 Days Number*
Bothered by Symptom in Past 30 Days*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	Receiving Help with Symptom* <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
Interested in Receiving Help with Symptom <i>Required if Receiving Help is No</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	

Mental Health Symptom*	<input type="checkbox"/> Experienced serious depression <input type="checkbox"/> Anxiety/Tension <input type="checkbox"/> Hallucinations <input type="checkbox"/> Attempted suicide <input type="checkbox"/> Trouble controlling violent behavior <input type="checkbox"/> Trouble understanding/ concentrating or remembering <input type="checkbox"/> Been prescribed medication for psychological/emotional problems <input type="checkbox"/> Refused	Symptom in Past 30 Days Number*
Bothered by Symptom in Past 30 Days*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	Receiving Help with Symptom* <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
Interested in Receiving Help with Symptom <i>Required if Receiving Help is No</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	

Medication Assisted Treatments

Required if Care Status Program Area is Substance Use

Medication Type*	<input type="checkbox"/> Methadone <input type="checkbox"/> Naltrexone <input type="checkbox"/> Disulfiram <input type="checkbox"/> Other	<input type="checkbox"/> Buprenorphine <input type="checkbox"/> Acamprosate <input type="checkbox"/> LAAM <input type="checkbox"/> None
------------------	--	--

Diagnoses

Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

Primary

Code Set Identifier*	<input type="checkbox"/> ICD-10	
----------------------	---------------------------------	--

Rank Number*	1	Diagnosis Code*
--------------	---	-----------------

Secondary

Code Set Identifier	<input type="checkbox"/> ICD-10	
---------------------	---------------------------------	--

Rank Number	2	Diagnosis Code
-------------	---	----------------

Tertiary

Code Set Identifier	<input type="checkbox"/> ICD-10	
---------------------	---------------------------------	--

Rank Number	3	Diagnosis Code
-------------	---	----------------

Stages of Change

Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

A Stage of Change is required for each positive Pre-Screening Program.

Program Area	<input type="checkbox"/> Substance Use Disorder Treatment	<input type="checkbox"/> Gambling Treatment
--------------	---	---

Stage	<input type="checkbox"/> I have no intentions of changing my behaviors	<input type="checkbox"/> I plan to quit or reduce my behaviors in the next month
	<input type="checkbox"/> I am considering reducing or stopping my behaviors within the next 6 months	<input type="checkbox"/> I have already begun to reduce/quit my behaviors in the past 6 months
	<input type="checkbox"/> I reduced/quit my behaviors over 6 months and have been able to maintain these changes	<input type="checkbox"/> Refused

Program Area	<input type="checkbox"/> Substance Use Disorder Treatment	<input type="checkbox"/> Gambling Treatment
Stage	<input type="checkbox"/> I have no intentions of changing my behaviors <input type="checkbox"/> I am considering reducing or stopping my behaviors within the next 6 months <input type="checkbox"/> I reduced/quit my behaviors over 6 months and have been able to maintain these changes	<input type="checkbox"/> I plan to quit or reduce my behaviors in the next month <input type="checkbox"/> I have already begun to reduce/quit my behaviors in the past 6 months <input type="checkbox"/> Refused

Quality of Life Measures

Required for Pre-Admission Care Status. Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

	Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
How would you rate your quality of life?*					
How satisfied are you with your health?*					
How satisfied are you with your ability to perform your daily living activities?*					
How satisfied are you with yourself?*					
How satisfied are you with your personal relationships?*					
How satisfied are you with the conditions of your living place?*					
How satisfied are you with your mental health?*					

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Do you have enough energy for everyday life?*					
Do you have enough money to meet your needs?*					

Gambling Wager Activity Type

Required if Care Status Program Area is Gambling.

Primary

Profile

Activity Type*	Activity Type Rank	1
<i>See vocabulary key for all Gambling Wager Activity Types. Use "None" only if Concerned Individual is Yes.</i>		
First Wager Age*	Past 30 Days Frequency*	<input type="checkbox"/> None in the past month <input type="checkbox"/> 1-2 days in the past week <input type="checkbox"/> Daily <input type="checkbox"/> 1-3 days in the past month <input type="checkbox"/> 3-6 days in the past week <input type="checkbox"/> Refused

Gambling Wager Activity Locations

Gambling Wager Location*	<input type="checkbox"/> Casino <input type="checkbox"/> Home or Friend's Home <input type="checkbox"/> Racetrack <input type="checkbox"/> Other Sporting Event <input type="checkbox"/> Smart Phone	<input type="checkbox"/> Convenience Store <input type="checkbox"/> Internet/Online (Computer) <input type="checkbox"/> School <input type="checkbox"/> Work <input type="checkbox"/> Other
--------------------------	--	---

Secondary

Profile

Activity Type*	Activity Type Rank	2
<i>See vocabulary key for all Gambling Wager Activity Types. Use "None" only if Concerned Individual is Yes.</i>		
First Wager Age*	Past 30 Days Frequency*	<input type="checkbox"/> None in the past month <input type="checkbox"/> 1-2 days in the past week <input type="checkbox"/> Daily <input type="checkbox"/> 1-3 days in the past month <input type="checkbox"/> 3-6 days in the past week <input type="checkbox"/> Refused

Gambling Wager Activity Locations

Gambling Wager Location*	<input type="checkbox"/> Casino <input type="checkbox"/> Home or Friend's Home <input type="checkbox"/> Racetrack <input type="checkbox"/> Other Sporting Event <input type="checkbox"/> Smart Phone	<input type="checkbox"/> Convenience Store <input type="checkbox"/> Internet/Online (Computer) <input type="checkbox"/> School <input type="checkbox"/> Work <input type="checkbox"/> Other
--------------------------	--	---

Tuberculosis Risk Responses (during treatment, more than one response may apply)

Tuberculosis Risk Responses should be provided if Pre-Screening results were positive for Tuberculosis Risk

Tuberculosis Risk Response Type	<input type="checkbox"/> Tuberculosis Test <input type="checkbox"/> Tuberculosis Counseling <input type="checkbox"/> Tuberculosis Medical Evaluation/ Treatment	Tuberculosis Risk Response Location	<input type="checkbox"/> Onsite <input type="checkbox"/> Offsite <input type="checkbox"/> Pending <input type="checkbox"/> Refused
------------------------------------	--	--	---

Tuberculosis Risk Response Type	<input type="checkbox"/> Tuberculosis Test <input type="checkbox"/> Tuberculosis Counseling <input type="checkbox"/> Tuberculosis Medical Evaluation/ Treatment	Tuberculosis Risk Response Location	<input type="checkbox"/> Onsite <input type="checkbox"/> Offsite <input type="checkbox"/> Pending <input type="checkbox"/> Refused
------------------------------------	--	--	---

Tuberculosis Risk Response Type	<input type="checkbox"/> Tuberculosis Test <input type="checkbox"/> Tuberculosis Counseling <input type="checkbox"/> Tuberculosis Medical Evaluation/ Treatment	Tuberculosis Risk Response Location	<input type="checkbox"/> Onsite <input type="checkbox"/> Offsite <input type="checkbox"/> Pending <input type="checkbox"/> Refused
------------------------------------	--	--	---
