

Optional TB Maritime Contact Investigation Outcome Reporting Form

1. PASSENGER CONTACT INFORMATION						
Last name, First name	Cabin #	Sex	DOB (mm/dd/yy) OR	Age (yrs)	Country of birth	Country of residence
(Auto-populated)						
Was contact a passenger or crew member? <input type="checkbox"/> Passenger <input type="checkbox"/> Crew member, specify occupation _____						
2. CONTACT INVESTIGATION OUTCOME FOR ABOVE-NAMED CONTACT						
Is contact still on this ship? <input type="checkbox"/> Yes, date due to disembark: __/__/____ <input type="checkbox"/> No, why not? <input type="checkbox"/> Returned to country of residence <input type="checkbox"/> Transferred to another ship of the same company <input type="checkbox"/> Disembarked in another country (specify): _____, Location (specify address): _____ <input type="checkbox"/> Other; _____ <input type="checkbox"/>						
Additional comments: 						
3. INTERVIEW INFORMATION						
Was contact interviewed? <input type="checkbox"/> No, why not? <input type="checkbox"/> Declined <input type="checkbox"/> Other (specify) _____ (Stop here) <input type="checkbox"/> Yes, date: __/__/____ (Continue)						
Has contact ever had a previous TST? If yes, has the result ever been positive? <input type="checkbox"/> Yes, Date: __/__/____ Result: _____ mm induration or <input type="checkbox"/> Unknown <input type="checkbox"/> No, Date of most recent negative result: __/__/____ Result: _____ mm induration or <input type="checkbox"/> Unknown <input type="checkbox"/> <input type="checkbox"/> Unknown						
Has contact ever had a previous IGRA? <input type="checkbox"/> Yes, has the result ever been positive? <input type="checkbox"/> No <input type="checkbox"/> Yes, Date: __/__/____ <input type="checkbox"/> No, date of most recent negative or indeterminate result: __/__/____ <input type="checkbox"/> Unknown						
Does contact have a history of previous treatment for LTBI or active TB? <input type="checkbox"/> No <input type="checkbox"/> Yes Has contact ever received BCG vaccine? <input type="checkbox"/> No <input type="checkbox"/> Yes; Approximately what age (yrs) _____ <input type="checkbox"/> Unknown						
Was this passenger a close contact of the index case other than on the conveyance? <input type="checkbox"/> No <input type="checkbox"/> Yes, type: <input type="checkbox"/> Household <input type="checkbox"/> Travel companion <input type="checkbox"/> Social <input type="checkbox"/> Work <input type="checkbox"/> Other _____						
Is this passenger a close contact with a known case of TB other than the person on the conveyance? <input type="checkbox"/> No <input type="checkbox"/> Yes; With whom? _____ Date of last exposure): __/__/__ <input type="checkbox"/> Unknown						
Date of last exposure with index case: __/__/____						
Did the contact experience any of the following symptoms? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown If yes, check the appropriate symptoms: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever; Onset Date: __/__/____ If measured, maximum temperature _____ °C/F <input type="checkbox"/> <input type="checkbox"/> Persistent cough; Onset Date: __/__/____ <input type="checkbox"/> With blood <input type="checkbox"/> Without blood <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Night sweats, Onset Date: __/__/____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unexplained weight loss; Onset Date: __/__/____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Severe fatigue; Onset Date: __/__/____						
Does the contact have a medical risk factor for TB progression? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> Yes, specify: _____ <input type="checkbox"/> Unknown						
3. TB SCREENING						
Was contact screened for TB infection? <input type="checkbox"/> Yes (Continue to next question) <input type="checkbox"/> No, why not? <input type="checkbox"/> Previous positive TST or IGRA, such as the QuantiFERON or T-Spot <input type="checkbox"/> History of previous treatment for LTBI or active TB <input type="checkbox"/> Declined <input type="checkbox"/> Failed appointment <input type="checkbox"/> Other (specify): _____ (Stop here)						
4. RESULTS OF TB SCREENING AND EVALUATION (Please complete all that apply)						

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Date of 1st TST placement: __/__/__ Date 1st TST read: __/__/__ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative, ____ mm induration
Date of 1st IGRA: __/__/__ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate
Date of 2nd TST placement: __/__/__ Date 2nd TST read: __/__/__ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative, ____ mm induration
Date of 2nd IGRA: __/__/__ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate
Was a chest X-ray done?: <input type="checkbox"/> No <input type="checkbox"/> Yes Date: __/__/__ Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, noncavitary <input type="checkbox"/> Abnormal, cavitary
Diagnosis: <input type="checkbox"/> No infection <input type="checkbox"/> LTBI <input type="checkbox"/> TB disease suspected <input type="checkbox"/> TB disease confirmed* *If TB disease was confirmed, was the genotype result the same as the index case? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was treatment prescribed? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes, for LTBI <input type="checkbox"/> Yes, for TB disease
Risk factors for prior TB infection (Please complete regardless of TST/IGRA results and check all that apply below): <input type="checkbox"/> No known risk factors other than conveyance <input type="checkbox"/> Born in a country with high TB prevalence (>20/100,000) (specify country) _____ <input type="checkbox"/> Ever lived in a country with high TB prevalence (>20/100,000) 1. Country _____ Duration: ____ <input type="checkbox"/> Months <input type="checkbox"/> Years Purpose (check all that apply): <input type="checkbox"/> Work <input type="checkbox"/> Student <input type="checkbox"/> Volunteer <input type="checkbox"/> Missionary <input type="checkbox"/> Other (specify): _____ 2. Country _____ Duration: ____ <input type="checkbox"/> Months <input type="checkbox"/> Years Purpose (check all that apply): <input type="checkbox"/> Work <input type="checkbox"/> Student <input type="checkbox"/> Volunteer <input type="checkbox"/> Missionary <input type="checkbox"/> Other (specify): _____ 3. Country _____ Duration: ____ <input type="checkbox"/> Months <input type="checkbox"/> Years Purpose (check all that apply): <input type="checkbox"/> Work <input type="checkbox"/> Student <input type="checkbox"/> Volunteer <input type="checkbox"/> Missionary <input type="checkbox"/> Other (specify): _____
5. COMMENTS [free text field]

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-XXXX