Form Approved
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Tuberculosis Contact Screening Form

Contact Name:	❑ Male ❑ Female	DOB: _____/_____/_____	Age:
Current Location:			

Contact Exposure History (During the Infectious Period)	
Contact's Relationship to Index:	**Date of Last Exposure:** _____/_____/_____
Location of Exposure:	
1. How much time did you spend **in the same room or house** as the index while he/she was contagious (during the infectious period)?	Number of days per week: Number of hours per day:
2. How much time did you spend **in a bar or drug-using location** as the index while he/she was contagious (during the infectious period)?	Number of days per week: Number of hours per day:
3. How much time did you spend in the same room **in the hospital** while he/she was contagious (during the infectious period)?	Number of days per week: Number of hours per day:
4. If you are a healthcare worker, did you perform any procedures on the index patient that may have caused them to cough (such as suctioning, collecting sputum, performing CPR, using a bag mask, or intubation)	❑Yes (If Yes, person is automatically a close contact) ❑No
IF YES, specify type of procedure(s) and date(s)	
5. Specify **other contact** setting and any related details	
➢ **Based upon the answers above, is this a "close" contact?** A "close" contact is a person who spent ≥4 hours multiple times *or* spent ≥8 hours at least one time inside the same room as the index patient (during the infectious period)?	❑**Yes** ❑**No**

TB Symptom Screening (Current Symptoms)		**Start Date and Duration**
Instructions: Screen to see if the contact *currently* has TB symptoms. Consider the contact "symptomatic for TB" if they have: (1) A cough for ≥2 weeks duration *OR* (2) Two "yes" responses to symptoms #2-8 that cannot be explained by another medical condition		
1. Have you been coughing for ≥2 weeks?	❑Yes ❑No	
2. Have you been coughing up blood?	❑Yes ❑No	

3. Have you had difficulty breathing?	❑Yes ❑No	
4. Have you had fevers or chills?	❑Yes ❑No	
5. Have you had night sweats? (completely soaking your clothes at night)	❑Yes ❑No	
6. Have you been tired or feeling weak lately?	❑Yes ❑No	
7. Have you lost your appetite?	❑Yes ❑No	
8. Have you had unplanned weight loss?	❑Yes ❑No ❑Unknown	If yes, how much?
➢ **Is this contact symptomatic for TB?**	**❑Yes ❑No** **If yes, specify symptom start date: ____/____/_____**	

TB Risk Factor Screening		**Notes**
Instructions: Screen to see if the contact has risk factors that could increase their risk for progression to active TB disease.		
1. Is this contact >50 years old?	❑Yes ❑No	
2. Was this contact <5 years old during the exposure period?	❑Yes ❑No	
3. Do you have diabetes?	❑Yes ❑No or Unknown	
4. Do you have HIV?	❑Yes ❑No or Unknown	
5. Do you have cancer?	❑Yes ❑No or Unknown	
6. Do you take prednisone every day?	❑Yes ❑No	
7. Do you smoke tobacco?	❑Yes ❑No	
8. Do you drink alcohol?	❑Yes ❑No	If yes, specify amount/frequency
9. Do you use any other substances?	❑Yes ❑No	If yes, include types/routes, frequency, and locations where substances acquired and used
➢ **Does this contact have a high-risk condition?** If the contact answers "yes" to **questions 1-6** above, then the contact has a high-risk condition.		**❑Yes ❑No**

Additional Questions
1. Have you ever been diagnosed with active TB disease? If so, please provide details including treatment if any.
2. Have you ever been diagnosed with latent TB infection? If so, please provide details including treatment if any.
3. **Have you ever known anybody with TB?** If yes, what was/is the nature of your relationship and contact? What did/does this person do during the day? How did/does he/she spend his/her time? Who spent/spends a lot of time with that person?

4. **Do you know anybody now who might have TB symptoms?**
(e.g., cough ≥2 weeks, fevers, chills, unintended weight loss)

END QUESTIONS

Test Results

	Date TST Placed	Date TST Read	MM
TST 1:			
TST 2:			
TST Interpretation: ❑ Negative ❑ Positive If pos, Conversion? ❑			

Chest X-Ray

CXR Date: _____/_____/_____

CXR Result: ❑ Not Suggestive of TB
❑ Suggestive of TB

Test Results

	Date of IGRA	IGRA Result
IGRA 1:		
IGRA 2:		
IGRA Interpretation: ❑ Negative ❑ Positive If pos, Conversion? ❑		

Chest X-Ray

CXR Date: _____/_____/_____

CXR Result: ❑ Not Suggestive of TB
❑ Suggestive of TB

Treatment

Rx Start Date:
_____/_____/_____

Rx End Date:
_____/_____/_____

Rx Regimen:

Treatment Outcome

❑ Completed LTBI treatment
❑ Adverse effects of medicine
❑ Lost to follow-up
❑ Refused treatment
❑ Provider decision to stop
❑ Moved
❑ Died
❑ Other (specify):
_____

TB Status

❑ LTBI ❑ TB Disease ❑ Not infected (test negative 8 weeks after last exposure) ❑ Lost to follow-up

Interviewer Name: _____ **Date:** _____/_____/_____