

Tuberculosis Contact Screening Form

Contact Name:	<input type="checkbox"/> Male <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes (If Yes, person is automatically a close contact) <input type="checkbox"/> 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 <i>OR</i> spent ≥8 hours at least one time inside the same room as the index patient (during the infectious period)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

3. Have you had difficulty breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Have you had fevers or chills?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Have you had night sweats? (completely soaking your clothes at night)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Have you been tired or feeling weak lately?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Have you lost your appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Have you had unplanned weight loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, how much?
➤ Is this contact symptomatic for TB?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Was this contact <5 years old during the exposure period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Do you have diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No or Unknown	
4. Do you have HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No or Unknown	
5. Do you have cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No or Unknown	
6. Do you take prednisone every day?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Do you smoke tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify amount/frequency
9. Do you use any other substances?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.		<input type="checkbox"/> Yes <input type="checkbox"/> 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 \geq 2 weeks, fevers, chills, unintended weight loss)

END QUESTIONS

Tact Results		Date TST Placed	Date TST Read	MM	Chest X-Ray
	TST 1:				CXR Date: ____/____/____ CXR Result: <input type="checkbox"/> Not Suggestive of TB <input type="checkbox"/> Suggestive of TB
	TST 2:				
TST Interpretation: <input type="checkbox"/> Negative <input type="checkbox"/> Positive If pos, Conversion? <input type="checkbox"/>					

Tact Results		Date of IGRA	IGRA Result	Chest X-Ray
	IGRA 1:			CXR Date: ____/____/____ CXR Result: <input type="checkbox"/> Not Suggestive of TB <input type="checkbox"/> Suggestive of TB
	IGRA 2:			
IGRA Interpretation: <input type="checkbox"/> Negative <input type="checkbox"/> Positive If pos, Conversion? <input type="checkbox"/>				

Treatment		Treatment Outcome
Rx Start Date: ____/____/____		<input type="checkbox"/> Completed LTBI treatment <input type="checkbox"/> Provider decision to stop <input type="checkbox"/> Adverse effects of medicine <input type="checkbox"/> Moved <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Died <input type="checkbox"/> Refused treatment <input type="checkbox"/> Other (specify): _____
Rx End Date: ____/____/____		
Rx Regimen:		

TB Status			
<input type="checkbox"/> LTBI	<input type="checkbox"/> TB Disease	<input type="checkbox"/> Not infected (test negative 8 weeks after last exposure)	<input type="checkbox"/> Lost to follow-up

Interviewer Name: _____

Date: ____/____/____