

TB Air Contact Investigation Outcome Reporting Form
FAX completed form to the CDC at 404.471.8121

1. FLIGHT INFORMATION (If more than one flight is listed, please circle the flight contact was on)				
CDC/QARS ID#	Arrival date	Departure Airport/City	Arrival Airport/City	Index Case Row
2. INDEX CASE CLINICAL AND LAB INFORMATION				
3. PASSENGER CONTACT INFORMATION				
Last name, First name	Assigned seat	Gender	DOB (mm/dd/yyyy)/Age (yrs)	
4. CONTACT INFORMATION				
<p>Were you able to contact this person? <input type="checkbox"/> No, why not? <input type="checkbox"/> Incorrect locating info <input type="checkbox"/> No longer at temporary address but still in the U.S. <input type="checkbox"/> Missed HD appointment <input type="checkbox"/> No response <input type="checkbox"/> Returned to country of residence <input type="checkbox"/> HD didn't attempt follow up <input type="checkbox"/> Other, specify _____ (Stop here) <input type="checkbox"/> Yes, date contacted: ___/___/___</p> <p>Was contact interviewed? <input type="checkbox"/> No, why not? <input type="checkbox"/> Declined <input type="checkbox"/> Lives in different jurisdiction, specify _____ <input type="checkbox"/> Other, specify _____ (Stop here) <input type="checkbox"/> Yes; actual/verified seat # _____,</p> <p>Was this person a known close contact of the index case outside of this flight (e.g. family member?) <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", date of last known exposure to index case: ___/___/___</p> <p>Country of birth: _____, Country of residence _____</p>				
5. INTERVIEW INFORMATION				
<p>Risk factors for prior TB infection (check all that apply below): <input type="checkbox"/> No known risk factors other than flight <input type="checkbox"/> Close contact of a person with a known case of TB other than the person on flight <input type="checkbox"/> Ever lived in a country with high TB prevalence*, specify _____ <input type="checkbox"/> Other risk factors (i.e. history of incarceration, homelessness, IV drug use), specify _____</p> <p>Does person have a history of previous TB? <input type="checkbox"/> No <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> Unknown</p> <p>Has person ever received BCG vaccine? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>Has this person ever had a TST performed prior to this flight? <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes, date of most recent (month/year): ___/___ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive</p> <p>Has this person ever had an IGRA performed prior to this flight? <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes, date of most recent (month/year): ___/___ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate</p> <p><small>*If you are unsure whether a country the contact lived in is considered high TB prevalence (greater than 20/100,000 cases), please list it in the specified field and we will make that determination for you upon receipt of the form.</small></p>				
6. TB SCREENING AND EVALUATION				
<p>Was person screened for TB infection after exposure on this flight? <input type="checkbox"/> No, why not? <input type="checkbox"/> Previous positive TB screening <input type="checkbox"/> Declined <input type="checkbox"/> Lost to follow up <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Yes, what type of testing? (check all that apply) <input type="checkbox"/> TST: Date of 1st TST read: ___/___/___ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date of 2nd TST read: ___/___/___ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> IGRA: Date of 1st IGRA: ___/___/___ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate Date of 2nd IGRA: ___/___/___ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate</p> <p>Was a review of signs and symptoms completed? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Was a chest X-ray done? <input type="checkbox"/> No <input type="checkbox"/> Yes, results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, non-cavitary <input type="checkbox"/> Abnormal, cavitary</p>				

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Diagnosis: No infection LTBI Active TB disease suspected Active TB disease confirmed Unknown
If diagnosed with TB, was treatment prescribed? No, why not? _____ Yes, date started ___/___/___

7. COMMENTS

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 0920-0900.