OMB Control No. 0920-0900 Expiration Date: xx/xx/20xx

TB Aircraft Contact Investigation Outcome Reporting Form

Return completed form by secure email to airadmin@cdc.gov (preferred) or fax to 404-471-8121 with the following text in the SUBJECT line: Outcome Reporting Form DGMH ID ######

| | ing Form DGMH ID ## | #### | | | | | |
|--|---------------------|-----------------------|--------|----------------------|-------------------|--------------------|--|
| 1. FLIGHT INFO | | | | | | | |
| DGMH ID# Arrival date De | | eparture Airport/City | | Arrival Airport/City | 7 | Index Case Seat | |
| | | | | | | | |
| 2. INDEX CASE CLINICAL AND LAB INFORMATION | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| 3. PASSENGER CONTACT INFORMATION | | | | | | | |
| Last name, First name Assigned seat Gender DOB (mm/dd/yyyy) Passport Country | | | | | | | |
| Lust hame, I list hame | | rissigned seat | Genaci | | 1 dsspor | - Lussport Country | |
| | | | | | | | |
| 4. CONTACT INFORMATION | | | | | | | |
| Were you able to contact this person? ☐ Yes ☐ No | | | | | | | |
| If no, why not? \square Incorrect locating info \square No longer at temporary address but still in the U.S. \square Returned to country of residence | | | | | | | |
| ☐ No response ☐ Other, specify(Skip to Section 7) | | | | | | | |
| If yes, date contacted: / / | | | | | | | |
| Was contact interviewed? Yes No | | | | | | | |
| Was contact interviewed? ☐ Yes ☐ No If no, why not? ☐ Declined ☐ Lives in different state/territory, specify | | | | | | | |
| Country of birth: Country of usual residence: | | | | | | | |
| 5. INTERVIEW INFORMATION | | | | | | | |
| | | (1 | | | | | |
| Social risk factors for prior TB infection (check all that apply below): | | | | | | | |
| □ No known risk factors other than flight □ Close contact of the index case outside the flight □ Close contact of a person with TB disease other than the index case | | | | | | | |
| □ Ever lived in a country with high TB prevalence*, specify | | | | | | | |
| ☐ Other risk factors for TB exposure, specify | | | | | | | |
| Has person ever received BCG vaccine? No Yes Unknown | | | | | | | |
| Has this person ever had a TST performed prior to this flight? | | | | | | | |
| ☐ Unknown ☐ No ☐ Yes, date of most recent (month/year):/ Result: ☐ Negative ☐ Positive | | | | | | | |
| Has this person ever had an IGRA performed prior to this flight? | | | | | | | |
| □ Unknown □ No □ Yes, date of most recent (month/year):/ Result: □ Negative □ Positive □ Indeterminate/borderline | | | | | | | |
| Has this person been previously diagnosed with TB/LTBI? □ No □ LTBI □ TB disease □ Unknown | | | | | | | |
| If yes, did they receive treatment? \square Yes \square No \square Unknown | | | | | | | |
| *If you are unsure whether a country is considered high TB prevalence (greater than 20/100,000 cases), please refer to the WHO's list of high TB burden countries. 6. TB SCREENING AND EVALUATION | | | | | | | |
| Did the person have signs and symptoms of TB? \(\text{TB} \) \(\text{No} \) \(\text{Not evaluated} \) | | | | | | | |
| Was person screened for TB infection after exposure on this flight? (As part of this evaluation or for another reason) \square Yes \square No | | | | | | | |
| If no, why not? \square Previous positive TB screening \square Declined \square Lost to follow up \square Other, specify | | | | | | | |
| If yes, what type of testing? (check all that apply) | | | | | | | |
| \square TST: Date of 1st TST read:/ / Results: \square Positive \square Negative | | | | | | | |
| Date of 2 nd TST read: / / Results: \square Positive \square Negative | | | | | | | |
| | | | | | | | |
| ☐ IGRA: Date of 1 st IGRA: / / Results: ☐ Positive ☐ Negative ☐Indeterminate/borderline | | | | | | | |
| Date of 2^{nd} IGRA: / / Results: \square Positive \square Negative \square Indeterminate/borderline | | | | | | | |
| Was a chest X-ray done? ☐ No ☐ Yes, results: ☐ Normal ☐ Abnormal, non-cavitary ☐ Abnormal, cavitary | | | | | | | |
| Diagnosis : ☐ No infection ☐ LTBI ☐ TB disease ☐ Undetermined | | | | | | | |
| If diagnosed with TB disease or LTBI, was treatment prescribed? Yes, date started // No, why not? | | | | | | | |
| 7. FORM COMP | LETION | | | | | | |
| Person(s) completing | ng the form: | | | Dat | e form completed: | / / | |
| 8. COMMENTS | | | | | | | |
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Public reporting burden of this collection of information is estimated to average 10 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 H-21-8, Atlanta, Georgia 30333; ATTN: PRA 0920-0900.