

Instructions for Completing the Tuberculosis Contact Investigation Form

The goals of a contact investigation are (1) rapid identification of individuals who are high and medium priority contacts to a known or suspected case of pulmonary, laryngeal or pleural TB; 2) timely initiation of appropriate treatment for those determined to be recently infected or exposed with a significant risk for progression to disease; and 3) identification and treatment of additional individuals found to have suspected TB disease in order to prevent further spread of disease.

This form is used by public health nurses (PHN) to guide and document the examination of contacts to active cases of pulmonary tuberculosis (TB) and the identification of the source of infection for cases of tuberculosis in children ≤ 6 yrs of age and tuberculin converters < 2 years of age. Aggregate contact investigation data are also used by the Alaska TB Program for management and evaluation.

The **initial copy** of the form should be submitted to the Alaska TB Program as soon as the first round of TSTs or IGRA testing are completed. This should occur within **10 business days after the index case is reported to the PHN**. Some data fields may not be known until the final copy of the form is completed (e.g. last exposure date). Leave those fields blank on the initial copy and complete on the final copy. The **final copy** should be submitted when contact follow-up is complete, or approximately **8 – 10 weeks after the index case was initially reported** to the PHN.

CASE

- **Demographics:** name, date of birth, race, gender at birth, phone number, address.
- **Infectious Period:** Review Table 1 to establish the infectious period. Additional epidemiologic or clinical factors may affect the infectious period and should be considered on a case-by-case basis.
- **Site of TB:** Indicate pulmonary or extra pulmonary.
- **Cavitary:** Select YES if the CXR interpretation indicated cavitary lesions.
- **Medication start date:** Enter the date that appropriate DOT drug therapy began (date first dose was administered via DOT).
- **Lab results:** AFB smear, PCR and sputum mycobacterial culture results. Enter the collection date of the initial positive specimen. Sensitivities to isoniazid, rifampin, ethambutol, pyrazinamide and streptomycin and start date of TB medications.

Table 1. Establishing an Infectious Period (IP)

Patients with sputum smear positive for AFB OR cavitary chest x-ray OR with TB symptoms (e.g. cough, hoarseness)	Patients with sputum smear negative for AFB, AND non-cavitary chest x-ray AND NO TB symptoms
<p>Date of Symptom onset: _____ or</p> <p>Date of first positive finding: _____</p> <p>IP Start Date: 3 months prior to symptom onset or 1st positive finding consistent with TB disease (whichever is longer): _____</p>	<p>Date treatment started: _____</p> <p>IP Start Date: 4 weeks prior to date of diagnosis (date treatment started): _____</p>
<p>1) Date 14th dose of DOT TB administered: _____</p> <p>2) Date 3rd consecutive AFB-negative smear sputa specimen was collected: _____</p> <p>3) Date clinical improvement noted: _____</p> <p>IP End Date: All three of the above criteria need to be met: completion and tolerance of 2 weeks of appropriate TB treatment (via DOT), 3 consecutive negative sputum AFB smears, and clinical improvement. The IP end date is the latest date out of the 3 criteria: _____</p>	<p>Date the 7th dose of DOT TB treatment administered: _____</p> <p>IP End Date: After 7 days of appropriate DOT, TB treatment, is taken and tolerated and no risk for drug resistance (Same date as recorded above): _____</p>

NOTE: For MDR cases regardless of sputum AFB smear status, cavitation on chest x-ray or TB symptoms, the closure of the infectious period will differ. MDR cases will require additional criteria of at least 3 consecutive negative sputum cultures without a subsequent positive culture and 14 days of TB treatment

Estimated Infectious Period: _____ **to** _____
Start **End**

Tool adapted from LA County Toolkit <http://publichealth.lacounty.gov/tb/docs/CIToolkit2013.pdf>

CONTACTS

- **Demographics:** name, date of birth, race, gender at birth, phone number, address and relationship to case, e.g., share same house-hold, co-worker, daughter, spouse, friend.
- **Contact Priority:** Any contacts who are not classified as high or medium priority are assigned a low priority. Review Table 2 to determine contact priorities.

Table 2. Contact Priorities

Contact Priority	
High	Includes contacts who meet the following criteria: household, ages <5 years, HIV or other medical risk, contact during bronchoscopy, sputum induction, etc., contact in congregate setting, or exceeds environmental limits
Medium	Includes contacts ages 5–15 years or who exceed environmental limits
Low	Includes all others
Consider window period prophylaxis for children < 5 years of age and immunocompromised persons.	

- **Dates exposed to infectious case:** Document the date the contact was first exposed to the index case WHILE the index case was considered infectious. Document the last day the contact was exposed to the index case WHILE the index case was considered infectious. Use the index case’s calculated infectious period to determine contact exposure dates. If contact is ongoing AND case is infectious, leave end date blank until final evaluation.
- **Historical Information, if available:**
 - Past TST or Past IGRA: Document screening results/date
 - Treatment History: Document prior LTBI or Active TB treatment/dates of treatment
- **Initial evaluation:**
 - Initial TST or IGRA: Document screening results/date
 - Symptom Screening: Select Yes if the contact has symptoms of tuberculosis such as cough, weight loss, fever, night sweats, fatigue, and/or hemoptysis. Document the date the symptom screening was done.
 - Sputa: If sputa were collected, document collection dates /results.
 - Chest X-ray: Document whether the CXR results were read as normal or abnormal. Provide brief details on abnormalities as noted by radiologist.
- **Final Evaluation:**
 - Follow-up TST or IGRA should be done 8 weeks after the last exposure to the index case while the index case was considered infectious. Document screening results/date
- **Contact’s Evaluation Summary:**
 - Evaluation complete: Select Yes or No, and the date and name of the PHN who completed the contact investigation.
 - Conclusion: Document the final status of the contact investigation.
 - Comments: Document any relevant details not captured in the form.

INDEX CASE Name:

DOB:

Infectious Period Start Date: _____ End Date: _____

INDEX CASE INFORMATION

Race:		Gender at Birth:		Phone Number:	
Address:			City:		Zip code:
Site of TB: <input type="checkbox"/> Pulmonary <input type="checkbox"/> Extrapulmonary			Cavitary: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Medication Start Date:
Lab Results	Smear: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		Date of Sputa Collection:		
	Culture: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		Sensitive to (select all that apply): <input type="checkbox"/> INH <input type="checkbox"/> RIF <input type="checkbox"/> EMB <input type="checkbox"/> PZA <input type="checkbox"/> STR		
	PCR: <input type="checkbox"/> Positive <input type="checkbox"/> Negative				

Contact Name:		Date of Birth:		Relationship to case:	
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low		Dates exposed to infectious case: Start Date		End Date	
Race:		Gender at Birth:		Phone Number:	
Address:			City:		Zip code:
Historical Information					
Past TST	Date:	Result:	mm	Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown	
Past IGRA	Date:	Result:		Start Date:	End Date:
Initial Evaluation					
Initial TST	Date:	Result:	mm	Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Initial IGRA	Date:	Result:		Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic	
Sputa	Date:	Smear:	Culture:	PCR:	Chest Xray: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):
	Date:	Smear:	Culture:	PCR:	
	Date:	Smear:	Culture:	PCR:	
Final Evaluation:					
Follow Up TST/IGRA 'F w g' F cvg'*: 'y ggmi' chngt "gzi quwt g' r gtlkf "gpf 'f cvg+<					
Follow-up TST	Date:	Result:	mm	Follow-up IGRA	Date: Result:
Contact's Evaluation Summary:					
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:			Comments:		
Completed by:					
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow-Up					

CLEAR FORM

INDEX CASE Name:

DOB:

Infectious Period Start Date: _____ End Date: _____

Contact Name:	Date of Birth:	Relationship to case:		
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Dates exposed to infectious case:	Start Date	End Date	
Race:	Gender at Birth:	Phone Number:		
Address:	City:	Zip code:		
Historical Information				
Past TST	Date:	Result:	mm	Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown
Past IGRA	Date:	Result:		Start Date: _____ End Date: _____
Initial Evaluation				
Initial TST	Date:	Result:	mm	Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____
Initial IGRA	Date:	Result:		Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic
Sputa	Date:	Smear:	Culture:	PCR:
	Date:	Smear:	Culture:	PCR:
	Date:	Smear:	Culture:	PCR:
Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No			Date: _____	
Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):				
Final Evaluation:				
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date): _____				
Follow-up TST	Date:	Result:	mm	Follow-up IGRA Date: _____ Result: _____
Contact's Evaluation Summary:				
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____			Comments:	
Completed by: _____				
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow-Up				

Contact Name:	Date of Birth:	Relationship to case:		
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Dates exposed to infectious case:	Start Date	End Date	
Race:	Gender at Birth:	Phone Number:		
Address:	City:	Zip code:		
Historical Information				
Past TST	Date:	Result:	mm	Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown
Past IGRA	Date:	Result:		Start Date: _____ End Date: _____
Initial Evaluation				
Initial TST	Date:	Result:	mm	Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____
Initial IGRA	Date:	Result:		Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic
Sputa Collected	Date:	Smear:	Culture:	PCR:
	Date:	Smear:	Culture:	PCR:
	Date:	Smear:	Culture:	PCR:
Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No			Date: _____	
Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):				
Final Evaluation:				
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date): _____				
Follow-up TST	Date:	Result:	mm	Follow-up IGRA Date: _____ Result: _____
Contact's Evaluation Summary:				
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____			Comments:	
Completed by: _____				
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow-Up				

INDEX CASE Name:

DOB:

Infectious Period Start Date: _____ End Date: _____

Contact Name:		Date of Birth:		Relationship to case:	
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low		Dates exposed to infectious case: Start Date		End Date	
Race:		Gender at Birth:		Phone Number:	
Address:		City:		Zip code:	
Historical Information					
Past TST	Date:	Result:	mm	Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown	
Past IGRA	Date:	Result:		Start Date: End Date:	
Initial Evaluation					
Initial TST	Date:	Result:	mm	Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Initial IGRA	Date:	Result:		Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic	
Sputa Collected	Date:	Smear:	Culture:	PCR:	Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:
	Date:	Smear:	Culture:	PCR:	Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):
	Date:	Smear:	Culture:	PCR:	
Final Evaluation:					
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):					
Follow-up TST	Date:	Result:	mm	Follow-up IGRA	Date: Result:
Contact's Evaluation Summary:					
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:			Comments:		
Completed by:					
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up					

Contact Name:		Date of Birth:		Relationship to case:	
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low		Dates exposed to infectious case: Start Date		End Date	
Race:		Gender at Birth:		Phone Number:	
Address:		City:		Zip code:	
Historical Information					
Past TST	Date:	Result:	mm	Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown	
Past IGRA	Date:	Result:		Start Date: End Date:	
Initial Evaluation					
Initial TST	Date:	Result:	mm	Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Initial IGRA	Date:	Result:		Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic	
Sputa Collected	Date:	Smear:	Culture:	PCR:	Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:
	Date:	Smear:	Culture:	PCR:	Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):
	Date:	Smear:	Culture:	PCR:	
Final Evaluation:					
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):					
Follow-up TST	Date:	Result:	mm	Follow-up IGRA	Date: Result:
Contact's Evaluation Summary:					
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:			Comments:		
Completed by:					
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up					

INDEX CASE Name:

DOB:

Infectious Period Start Date: _____ End Date: _____

Contact Name:	Date of Birth:	Relationship to case:		
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Dates exposed to infectious case:		Start Date	End Date
Race:	Gender at Birth:	Phone Number:		
Address:	City:	Zip code:		
Historical Information				
Past TST	Date:	Result:	mm	Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown
Past IGRA	Date:	Result:		Start Date: _____ End Date: _____
Initial Evaluation				
Initial TST	Date:	Result:	mm	Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____
Initial IGRA	Date:	Result:		Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic
Sputa Collected	Date:	Smear:	Culture:	PCR:
	Date:	Smear:	Culture:	PCR:
	Date:	Smear:	Culture:	PCR:
Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____				
Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify): _____				
Final Evaluation:				
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date): _____				
Follow-up TST	Date:	Result:	mm	Follow-up IGRA Date: _____ Result: _____
Contact's Evaluation Summary:				
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____			Comments:	
Completed by: _____				
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up				

Contact Name:	Date of Birth:	Relationship to case:		
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Dates exposed to infectious case:		Start Date	End Date
Race:	Gender at Birth:	Phone Number:		
Address:	City:	Zip code:		
Historical Information				
Past TST	Date:	Result:	mm	Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown
Past IGRA	Date:	Result:		Start Date: _____ End Date: _____
Initial Evaluation				
Initial TST	Date:	Result:	mm	Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____
Initial IGRA	Date:	Result:		Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic
Sputa Collected	Date:	Smear:	Culture:	PCR:
	Date:	Smear:	Culture:	PCR:
	Date:	Smear:	Culture:	PCR:
Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____				
Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify): _____				
Final Evaluation:				
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date): _____				
Follow-up TST	Date:	Result:	mm	Follow-up IGRA Date: _____ Result: _____
Contact's Evaluation Summary:				
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____			Comments:	
Completed by: _____				
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up				

INDEX CASE Name:

DOB:

Infectious Period Start Date: _____ End Date: _____

Contact Name:			Date of Birth:			Relationship to case:		
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low			Dates exposed to infectious case: Start Date			End Date		
Race:			Gender at Birth:			Phone Number:		
Address:			City:			Zip code:		
Historical Information								
Past TST Date: Result: mm			Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown					
Past IGRA Date: Result:			Start Date:			End Date:		
Initial Evaluation								
Initial TST Date: Result: mm			Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:					
Initial IGRA Date: Result:			Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic					
Sputa Collected Date: Smear: Culture: PCR:			Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:					
Date: Smear: Culture: PCR:			Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):					
Date: Smear: Culture: PCR:								
Final Evaluation:								
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):								
Follow-up TST Date: Result: mm			Follow-up IGRA Date:			Result:		
Contact's Evaluation Summary:								
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:				Comments:				
Completed by:								
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up								

Contact Name:			Date of Birth:			Relationship to case:		
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low			Dates exposed to infectious case: Start Date			End Date		
Race:			Gender at Birth:			Phone Number:		
Address:			City:			Zip code:		
Historical Information								
Past TST Date: Result: mm			Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown					
Past IGRA Date: Result:			Start Date:			End Date:		
Initial Evaluation								
Initial TST Date: Result: mm			Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:					
Initial IGRA Date: Result:			Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic					
Sputa Collected Date: Smear: Culture: PCR:			Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:					
Date: Smear: Culture: PCR:			Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):					
Date: Smear: Culture: PCR:								
Final Evaluation:								
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):								
Follow-up TST Date: Result: mm			Follow-up IGRA Date:			Result:		
Contact's Evaluation Summary:								
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:				Comments:				
Completed by:								
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up								

INDEX CASE Name:

DOB:

Infectious Period Start Date: _____ End Date: _____

Contact Name:				Date of Birth:				Relationship to case:			
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low				Dates exposed to infectious case: Start Date				End Date			
Race:				Gender at Birth:				Phone Number:			
Address:				City:				Zip code:			
Historical Information											
Past TST Date: Result: mm				Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown							
Past IGRA Date: Result:				Start Date:				End Date:			
Initial Evaluation											
Initial TST Date: Result: mm				Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:							
Initial IGRA Date: Result:				Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic							
Sputa Collected Date: Smear: Culture: PCR:				Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:							
Date: Smear: Culture: PCR:				Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):							
Date: Smear: Culture: PCR:											
Final Evaluation:											
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):											
Follow-up TST Date: Result: mm				Follow-up IGRA Date:				Result:			
Contact's Evaluation Summary:											
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:						Comments:					
Completed by:											
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up											

Contact Name:				Date of Birth:				Relationship to case:			
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low				Dates exposed to infectious case: Start Date				End Date			
Race:				Gender at Birth:				Phone Number:			
Address:				City:				Zip code:			
Historical Information											
Past TST Date: Result: mm				Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown							
Past IGRA Date: Result:				Start Date:				End Date:			
Initial Evaluation											
Initial TST Date: Result: mm				Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:							
Initial IGRA Date: Result:				Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic							
Sputa Collected Date: Smear: Culture: PCR:				Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:							
Date: Smear: Culture: PCR:				Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):							
Date: Smear: Culture: PCR:											
Final Evaluation:											
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):											
Follow-up TST Date: Result: mm				Follow-up IGRA Date:				Result:			
Contact's Evaluation Summary:											
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:						Comments:					
Completed by:											
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up											

INDEX CASE Name:

DOB:

Infectious Period Start Date: _____ End Date: _____

Contact Name:		Date of Birth:			Relationship to case:	
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low		Dates exposed to infectious case: Start Date			End Date	
Race:		Gender at Birth:			Phone Number:	
Address:		City:			Zip code:	
Historical Information						
Past TST	Date:	Result:	mm	Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown		
Past IGRA	Date:	Result:		Start Date: End Date:		
Initial Evaluation						
Initial TST	Date:	Result:	mm	Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:		
Initial IGRA	Date:	Result:		Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic		
Sputa Collected	Date:	Smear:	Culture:	PCR:	Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
	Date:	Smear:	Culture:	PCR:	Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):	
	Date:	Smear:	Culture:	PCR:		
Final Evaluation:						
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):						
Follow-up TST	Date:	Result:	mm	Follow-up IGRA	Date:	Result:
Contact's Evaluation Summary:						
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:				Comments:		
Completed by:						
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up						

Contact Name:		Date of Birth:			Relationship to case:	
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low		Dates exposed to infectious case: Start Date			End Date	
Race:		Gender at Birth:			Phone Number:	
Address:		City:			Zip code:	
Historical Information						
Past TST	Date:	Result:	mm	Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown		
Past IGRA	Date:	Result:		Start Date: End Date:		
Initial Evaluation						
Initial TST	Date:	Result:	mm	Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:		
Initial IGRA	Date:	Result:		Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic		
Sputa Collected	Date:	Smear:	Culture:	PCR:	Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
	Date:	Smear:	Culture:	PCR:	Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):	
	Date:	Smear:	Culture:	PCR:		
Final Evaluation:						
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):						
Follow-up TST	Date:	Result:	mm	Follow-up IGRA	Date:	Result:
Contact's Evaluation Summary:						
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:				Comments:		
Completed by:						
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up						

INDEX CASE Name:

DOB:

Infectious Period Start Date: _____ End Date: _____

Contact Name:			Date of Birth:			Relationship to case:		
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low			Dates exposed to infectious case: Start Date			End Date		
Race:			Gender at Birth:			Phone Number:		
Address:			City:			Zip code:		
Historical Information								
Past TST Date: Result: mm			Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown					
Past IGRA Date: Result:			Start Date:			End Date:		
Initial Evaluation								
Initial TST Date: Result: mm			Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:					
Initial IGRA Date: Result:			Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic					
Sputa Collected Date: Smear: Culture: PCR:			Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:					
Date: Smear: Culture: PCR:			Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):					
Date: Smear: Culture: PCR:								
Final Evaluation:								
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):								
Follow-up TST Date: Result: mm			Follow-up IGRA Date:			Result:		
Contact's Evaluation Summary:								
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:				Comments:				
Completed by:								
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up								

Contact Name:			Date of Birth:			Relationship to case:		
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low			Dates exposed to infectious case: Start Date			End Date		
Race:			Gender at Birth:			Phone Number:		
Address:			City:			Zip code:		
Historical Information								
Past TST Date: Result: mm			Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown					
Past IGRA Date: Result:			Start Date:			End Date:		
Initial Evaluation								
Initial TST Date: Result: mm			Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:					
Initial IGRA Date: Result:			Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic					
Sputa Collected Date: Smear: Culture: PCR:			Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:					
Date: Smear: Culture: PCR:			Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):					
Date: Smear: Culture: PCR:								
Final Evaluation:								
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):								
Follow-up TST Date: Result: mm			Follow-up IGRA Date:			Result:		
Contact's Evaluation Summary:								
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:				Comments:				
Completed by:								
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up								

INDEX CASE Name:

DOB:

Infectious Period Start Date: _____ End Date: _____

Contact Name:				Date of Birth:				Relationship to case:			
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low				Dates exposed to infectious case: Start Date				End Date			
Race:				Gender at Birth:				Phone Number:			
Address:				City:				Zip code:			
Historical Information											
Past TST Date: Result: mm				Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown							
Past IGRA Date: Result:				Start Date:				End Date:			
Initial Evaluation											
Initial TST Date: Result: mm				Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:							
Initial IGRA Date: Result:				Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic							
Sputa Collected Date: Smear: Culture: PCR:				Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:							
Date: Smear: Culture: PCR:				Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):							
Date: Smear: Culture: PCR:											
Final Evaluation:											
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):											
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Contact's Evaluation Summary:											
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:						Comments:					
Completed by:											
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up											

Contact Name:				Date of Birth:				Relationship to case:			
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low				Dates exposed to infectious case: Start Date				End Date			
Race:				Gender at Birth:				Phone Number:			
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Historical Information											
Past TST Date: Result: mm				Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown							
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Initial Evaluation											
Initial TST Date: Result: mm				Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:							
Initial IGRA Date: Result:				Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic							
Sputa Collected Date: Smear: Culture: PCR:				Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:							
Date: Smear: Culture: PCR:				Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):							
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Contact's Evaluation Summary:											
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:						Comments:					
Completed by:											
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up											

INDEX CASE Name:

DOB:

Infectious Period Start Date: _____ End Date: _____

Contact Name:				Date of Birth:				Relationship to case:			
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low				Dates exposed to infectious case: Start Date				End Date			
Race:				Gender at Birth:				Phone Number:			
Address:				City:				Zip code:			
Historical Information											
Past TST Date: Result: mm				Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown							
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Initial Evaluation											
Initial TST Date: Result: mm				Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:							
Initial IGRA Date: Result:				Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic							
Sputa Collected Date: Smear: Culture: PCR:				Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:							
Date: Smear: Culture: PCR:				Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):							
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Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):											
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Contact's Evaluation Summary:											
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:						Comments:					
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Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up											

Contact Name:				Date of Birth:				Relationship to case:			
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low				Dates exposed to infectious case: Start Date				End Date			
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Initial TST Date: Result: mm				Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:							
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Sputa Collected Date: Smear: Culture: PCR:				Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:							
Date: Smear: Culture: PCR:				Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):							
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Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):											
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Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:						Comments:					
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