Attachment A

Idaho TB Contact Tracing Form—*Return with CDC "Report of Verified Case of Tuberculosis Follow Up Report-2"*

Case Name: _____ **Year Reported:** _____ **Number of Contacts Identified:** _____

List of contacts (use additional sheets if necessary):

Name	Relationship to Case (family, co-worker, etc.)	Date First Evaluated	PPD Tested?	PPD Result	CXR?	CXR Result	Infection status (uninfected, infected, active TB, or unknown)	Started on PPx? (INH or other)	Date PPx Started	Date PPx Last Taken	PPX Completed? If PPx not Completed, Reason*:
Bob Contact	*Brother of case*	*01/01/2000*	*Y*	*10mm*	*Y*	*Negative*	*Infected*	*Y – INH*	*01/06/2000*	*05/06/2000*	*No. 2*

***Reasons for not finishing PPx (pick the best option):** **1. Death; 2. Moved AND unable to locate for follow-up; 3. Adverse effect of medication; 4. Contact chose to stop despite indication for continuation of PPx; 5. Contact lost to follow-up; 6. Provider decision**

TB CONTACT INVESTIGATION REPORT

Today's Date: ____________________ Submitted by: ______________________________________ Agency: ____

Contact Risk Factors: 1. Household contact; 2. Less than 5 yo; 3. Contact has med risk factor (HIV); 4. Exposed during medical procedure; 5. Exposed congregate setting; 6. Exceeds duration environment limits; 7. CXR consistent with previous TB; 8. 5-15yo of age

Case Name: ____ County/Tribal/ IHS: ____

List of Contacts: 1. Name 2. Relationship to TB case 3. Address	**DOB**	**Contact Risk Factors And Dates** (see above)	**Initial TST**		**2nd TST** 8-10 weeks		**X-Ray** If patient less than 5 years old, must have both posterior & lateral x-rays		**Treatment of LTBI**		**If Treatment is not completed give reason**
			Date	Result mm	Date	Result mm	Date	Result	Med & Start Date	Completion Date	
1. ____________ 2. ____________ 3. ____________											____ Death ____ Adverse Reaction ____ Patient Decision ____ Active TB developed ____ Lost to follow-up ____ Moved – provide address
1. ____________ 2. ____________ 3. ____________											____ Death ____ Adverse Reaction ____ Patient Decision ____ Active TB developed ____ Lost to follow-up ____ Moved - provide address
1. ____________ 2. ____________ 3. ____________											____ Death ____ Adverse Reaction ____ Patient Decision ____ Active TB developed ____ Lost to follow-up ____ Moved - provide address
1. ____________ 2. ____________ 3. ____________											____ Death ____ Adverse Reaction ____ Patient Decision ____ Active TB developed ____ Lost to follow-up ____ Moved - provide address
1. ____________ 2. ____________ 3. ____________											____ Death ____ Adverse Reaction ____ Patient Decision ____ Active TB developed ____ Lost to follow-up ____ Moved - provide address

Washington State Department of Health

Tuberculosis Contact Investigation Form

Submitted By:_____
Date:_____

Case

Name: (last) (first) (MI) (also known as)

DOB: | Age: | RVCT:

Morbidity Date:

County: | Comments:

Type: ☐ Pulmonary ☐ Non Pulmonary CXR Results: ☐ Cavitary ☐ Noncavitary

Contact

Priority of exposed contact

(please refer to CI Instructions for definitions)

☐ **Category 1: Smear positive or cavitary chest x-ray**

☐ **Category 2: Smear negative**

☐ **Category 3: Suspect case**

Contact Investigation

Date Identified:_____

Date Interviewed:_____

Date of Evaluation:_____

Contact Risk Factors (Mark Y =Yes or N = No in chart below)

1. Household
2. Less than 5 years of age
3. Contact has medical risk factor (i.e. HIV)
4. Exposed during medical procedure
5. Exposed congregate Setting
6. Exceeds duration environment limits
7. 5 - 15 years of age

Full Name of Contact	Date of Birth	*Exposure category	Household	< 5 years	Med risk	Medical exposure	Cong Set	Enviro limits	5 – 15 years	CXR- prev TB	TST Results/ QFT-G Results			Current Chest X-Ray	Treatment of LTBI	**** Completion Date or Discontinued Due to:
											**Prior Positive	Initial TST or QFT-G ***	8 – 10 week retest			
1.												Date: TST mm: QFT-G:	Date: TST mm: QFT-G:	Date:_____ ☐ Normal ☐ Abnormal	☐ Yes Date:_____ Drug (s)_____ ☐ No Reason:_____	
2.												Date: TST mm: QFT-G:	Date: TST mm: QFT-G:	Date:_____ ☐ Normal ☐ Abnormal	☐ Yes Date:_____ Drug (s)_____ ☐ No Reason:_____	
3.												Date: TST mm: QFT-G:	Date: TST mm: QFT-G:	Date:_____ ☐ Normal ☐ Abnormal	☐ Yes Date:_____ Drug (s)_____ ☐ No Reason:_____	
4.												Date: TST mm: QFT-G:	Date: TST mm: QFT-G:	Date:_____ ☐ Normal ☐ Abnormal	☐ Yes Date:_____ Drug (s)_____ ☐ No Reason:_____	
5.												Date: TST mm: QFT-G:	Date: TST mm: QFT-G:	Date:_____ ☐ Normal ☐ Abnormal	☐ Yes Date:_____ Drug (s)_____ ☐ No Reason:_____	

***Exposure Category**
H= High
M= Medium
L= Low

****Prior Positive**
(1) = Follow-up needed
(2) = Follow-up not needed

*****Quantiferon-GOLD Results**
(1) = Positive
(2) = Negative
(3) = Indeterminate

******Completion date or discontinued due to:**
(C) = Completed treatment
(D) = Died during treatment
(L) = Lost
(M) = Moved & Records Referred
(P) = Provider Discontinued Meds
(R) = Refused to continue
(T) = TB Disease Diagnosed

TB Contact Investigation Summary

Due at the completion of each contact investigation - After all contacts on treatment for LTBI have completed therapy or have discontinued drug therapy

Montana Department of Public Health & Human Services
TB Program, Cogswell Building, Room C-216
1400 Broadway, Helena, MT 59620
Phone: 406-444-0275; Fax: 406-444-0272

Today's Date _____
Submitted by _____
Date Case Reported _____
County _____

Case Name _____

1. The case had: (check one)
   ___ pulmonary TB with AFB sputum smear positive
   ___ pulmonary TB with AFB sputum smear negative
   ___ non-pulmonary TB
   ___ other _____

2. Number of contacts identified _____

3. Number of contacts evaluated _____
   (initial TST placed & read, follow-up TST placed & read if indicated, and chest x-ray)

4. Number of contacts that were diagnosed with active TB disease as a result of this contact investigation _____ (This will trigger a separate contact investigation.)

5. Number of contacts that were diagnosed with latent TB infection (LTBI) as a result of this contact investigation _____
   a. Number that started treatment for LTBI _____
   b. Number of contacts that completed recommended treatment _____

6. For contacts not completing treatment for LTBI:
   a. Number who died before completing therapy _____
   b. Number who moved before completing therapy with no follow-up information _____
   c. Number who developed active TB disease during the course of therapy _____
   d. Number who stopped treatment due to side effects/adverse reactions _____
   e. Number who chose to stop treatment without any contraindications _____
   f. Number who stopped treatment on provider's advice _____
   g. Number lost to follow-up _____

Evaluation Indices for Contact Investigation:

1. Percentage of contacts evaluated _____ (MT goal: 95% of contacts to AFB-positive smear cases are evaluated)

2. Percentage of contacts who were diagnosed with LTBI _____

3. Percentage of contacts with LTBI who completed treatment _____ (MT goal: 80% of contacts with LTBI will complete treatment)