TB Contact Reporting Requirements for Correctional and Detention Facilities

Name of person completing this form: _____ Date: _____

I. INDEX CASE

Last Name: _____ First Name: _____ Middle: _____

DOB: _____ Social Security Number: _____ DOC number: _____

Major Site of Disease: _____

Date of Incarceration: _____ Date of Isolation: _____ Start Date of Symptoms: _____

Infectiousness period start date: _____ Infectiousness period end date: _____

TST Date and Results: _____ Initial CXR Date and Results: _____

Sputum Smear Date and Results: _____
(AFBx3)

NAA (MTD) Date and Results: _____ Sputum Culture Date and Results: _____

Susceptibility Results: _____

Initial Drug Regimen: _____ Date Started: _____

HIV Status: _____

Movement Information: (please attach):

Additional Comments:

_____

_____

_____

_____

II. CONTACT

Client Demographics

Contact Last Name: _____ First Name: _____ Middle: _____

DOB: _____ Social Security Number: _____ Gender: ○ M ○ F

Client DOC number (if applicable): _____

Race(s) (select all that apply):

☐ American Indian or Alaskan Native ☐ Asian; optional, specify: _____ ☐ White

☐ Black/African American ☐ Native Hawaiian or Pacific Islander; optional, specify: _____

Ethnicity: ○ Non-Hispanic ○ Hispanic

Client Address

Date Arrived at Current Facility: _____

Current Facility Name: _____

Street address: _____

Zip: _____ City: _____ County: _____

Telephone: _____ Contact Person: _____

Unit or Dorm:_____

Was the contact homeless at any time during the 12 months prior to this report? ○ Yes ○ No

Previous Facility Name (if applicable): _____

Street address: _____

Zip: _____ City: _____ County: _____

Home Street Address: _____

Zip: _____ City: _____ County: _____

Extended Demographics

Country of Birth: _____ If not US, Date Arrived in US*: _____
* This date may be precise, i.e. month/day/year; or imprecise, i.e. month/year or year.

Contact Details

Relationship to the index case: _____(i.e. staff, inmate)

Priority: ◯ High ◯ Medium ◯ Low

Date the contact was last exposed to the index case: _____ Estimated # of hours of exposure: _____

Facility exposure occurred: _____

Street Address: _____

ZIP: _____ City: _____ County: _____

Unit or Dorm: _____Telephone: _____
Contact person: _____

Assessment

History of previous TST or IGRA: ◯ Yes ◯ No ◯ Unknown
If YES, Date Read and Results: _____

Most Recent TST or IGRA:
Date TST Administered: _____ Date Read: _____ Results: _____MM
Date of IGRA Test: _____ Results: _____
History of TB disease: Yes No If YES, Where_____; Date Therapy Started: _____ Stopped: _____
Mode of Tx: _____ Regimen: _____Disposition:_____

History of LTBI Tx: Yes No If YES, Where_____; Date Therapy Started: _____ Stopped: _____
Mode of Tx_____; Regimen: _____ Disposition: _____

Symptoms:
Date of assessment: _____
Cough for more than 2 wks ◯ Yes ◯ No
Weight loss ◯ Yes ◯ No
Night sweats (over 2 wks) ◯ Yes ◯ No
Fever for more than week ◯ Yes ◯ No
Hoarseness (over 3 wks) ◯ Yes ◯ No
Hemoptysis ◯ Yes ◯ No
Other (specify) ◯ Yes ◯ No Specify: _____

Risk Factors (check all that apply)**:**
☐Recent arrival from high TB prevalence country; ☐Renal failure; ☐Cancer (head/neck/lung); ☐Organ transplant; ☐Diabetes mellitus; ☐Immunosuppressive Meds (e.g., steroids); ☐Silicosis; ☐Gastrectomy; ☐IV drug use
☐Other (specify)_____

Radiological Exam

Date of Exam: _____ Type of Exam: ☐X-Ray ☐CT Scan ☐Other: _____

Date of Findings/Interpretation: _____ Results: ◯ Abnormal* ◯ Normal ◯ Unknown

*Cavitation: ◯ Cavitary ◯ Non-Cavitary, Consistent with TB ◯ Non-Cavitary, Not Consistent with TB ◯ Unknown
*Stability: ◯ Improving ◯ Stable ◯ Worsening ◯ Unknown

HIV Testing

HIV Status Date: _____

HIV Status: ◯Negative ◯Positive* ◯Indeterminate ◯Refused ◯Not Offered ◯Unknown

*If Positive, Result Verification: ☐Medical Documentation ☐Patient History ☐Unknown

Labs

Initial Sputum Smear Results (x3): ◯ Positive ◯ Negative ◯ Not Done ◯ Unknown Date:_____
◯ Positive ◯ Negative ◯ Not Done ◯ Unknown Date:_____
◯ Positive ◯ Negative ◯ Not Done ◯ Unknown Date:_____

NAA (MTD) Results: ◯ Positive ◯ Negative ◯ Not Done ◯ Indeterminate Date:_____

Sputum Culture Results: ◯ Positive ◯ Negative ◯ Not Done ◯ Unknown Date:_____

Microscopic Exam of Tissue/Other Body Fluids: ◯ Positive* ◯ Negative ◯ Not Done ◯ Unknown

*If positive, list anatomic site(s):
_____

Culture of Tissue/Other Body Fluids: ◯ Positive* ◯ Negative ◯ Not Done ◯ Unknown

*If positive, list anatomic site(s):
_____

Medication

Date Therapy Started: _____

☐ Isoniazid _____mg ☐ Rifampin _____mg ☐ Other, please specify _____ _____mg

Date Therapy Stopped: _____ Disposition:_____

Additional Information/Comments regarding the contact:

_____

_____

_____

For DOH Bureau of TB use only

Forwarded to: _____
Date forwarded: _____