

* Findings consistent with ATBD include, but are not limited to: specimen which suggests/confirms TB diagnosis (positive AFB smear, nucleic acid amplification test (NAAT) for *M.tb*, or *M.tb* culture); chest x-ray showing abnormality consistent with TB; or initiation of treatment for TB. **The American Academy of Pediatrics does not recommend routine IGRAs for children <5 yrs; these should only be drawn with MD order.

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INSTRUCTIONS FOR COMPLETING THE CONTACT INVESTIGATION (CI) RECORD

This form is to be completed by the case manager as the tuberculosis (TB) contact investigation is undertaken. Some of the fields are clarified below. Refer to the CDC's Contact Investigation Guidelines for further guidance (www.cdc.gov/tb/publications/guidelines/ContactInvestigations.htm).

Date case reported: The date the TB case/suspect was reported to the local health district (LHD).

Date CI started: This is the date when *first inquiries* about potential contacts to the index case are made – *not* the date when the site visit to start contact evaluations is made. The contact investigation often starts during the first interview.

Infectious period from ____ to ____: Applicable when disease site is the respiratory system, including the airways.

The **beginning** of likely period of infectiousness:

- 12 weeks prior to symptoms onset or first positive finding consistent with TB* - whichever is longer.

The **end** of likely period of infectiousness is when patients meet all the following criteria:

- have three consecutive negative acid-fast bacilli (AFB) sputum smears from sputa collected at least 8 hours apart with at least one being an early morning collection;
- have completed at least two weeks of anti-tuberculosis therapy consistent with the current treatment guidelines; and
- exhibit clinical improvement.

Contact Risk Factors: Mark whether contact is <5 years, HIV-infected, or otherwise immunocompromised (IC). Children <5 years of age with a negative (<5 mm) tuberculin skin test (TST)** placed less than 8 weeks after last exposure to an infectious patient should start treatment for latent TB infection (LTBI) after active TB disease (ATBD) has been ruled out (window period prophylaxis). A second TST is placed ≥8 weeks following last infectious exposure. If the second TST is negative, LTBI treatment is usually stopped. If the second TST is positive, treatment for LTBI should be completed. Refer to Figure 5 in CI Guidelines. HIV-infected or other IC contacts may be given a full course of treatment for LTBI, regardless of their TST/interferon-γ release assay (IGRA) results, because of the possibility of a false-negative result. Refer to Figure 6 in CI Guidelines.

Contact Type: Contact type is dependent on the characteristics of the index case; the duration and circumstances of exposure; and the susceptibility of the contact. Refer to Figures 2 to 9 in the CI Guidelines for further guidance on prioritizing and evaluating contacts. All high- and medium-priority contacts should be identified, located, and evaluated as soon as possible. Low-priority contacts can receive one TST/IGRA at the end of the window period; refer to Figure 8 in the CI Guidelines. Non-contacts (NC) are persons who probably did not share air with the index case but request inclusion in the contact investigation; evaluation of non-contacts is discouraged.

Date Last Infectious Exposure: Date of contact's last exposure to the index case while he/she was infectious.

Previous Positive (Prev +) and Documentation Available (Doc): Circle whether the contact reports a previous positive TST/IGRA and whether documentation of this previous result was available. Previous positive contacts without documentation should be retested. For contacts with documented previous positive test results, refer to Figure 9 in CI Guidelines.

TST/IGRA Results: Note the date and result of testing. TSTs are reported in mm; IGRAs as positive, negative, or indeterminate. If necessary, a second TST/IGRA should be placed ≥8 weeks after the contact's last infectious exposure to the index case. Refer to Figures 5 to 9 in CI Guidelines.

Current Chest X-ray: Note the date and result of the current chest x-ray.

Dx: Circle the appropriate diagnosis after all necessary tests and exams have been completed.

Newly-diagnosed LTBI Treatment: Only *newly-diagnosed* LTBI need to be tracked for LTBI treatment on this form.

Previously-diagnosed LTBI (with or without documentation) should be tracked on the TB Monthly Activity Report.

DOPT: Indicate if directly observed preventive therapy (DOPT) was given. Children <5 years of age who are contacts of infectious cases should have their LTBI treatment administered using DOPT.

Finish Tx/Reason Not Finished: Circle Yes if LTBI treatment was completed. If treatment was not finished, note the reason for non-completion:

1 – Death: Contact died before completion of treatment. 2 - Contact Moved: Contact moved and follow-up information was unavailable. If follow-up information is available, classify the

contact's outcome accordingly. 3 – ATBD Developed: Contact was receiving treatment for LTBI but developed ATBD. 4 – Adverse Effect of Medicine: A *health care provider* documents that anti-TB medication should be discontinued because of an adverse

effect (including drug or drug-food interactions) of anti-TB medication. 5 – Contact Chose to Stop: Contact decides to stop taking medication before finishing the regimen. 6 – Contact Lost to Follow-up: Contact whose treatment status at the anticipated end of the treatment regimen is incomplete or unknown

because the LHD could not locate them to determine a more specific outcome. 7 – Provider Decision: A health care provider determines that treatment for LTBI should be stopped because of concerns about the

benefits, safety, or practicality of treatment (eg a contact had such erratic attendance at the clinic that the adequacy and safety of the treatment could not be monitored).