TB Program Evaluation

Report of Follow-up and Treatment for Contacts to TB Cases and Suspects

Date __/__/____

RVCT #: _____-___-_____

A. Case/Suspect Information

Last Name	First Name	Middle Name	DOB	SSN	Sex	Race	Ethnicity
			__/__/____	___-__-____	☐ M ☐ F	☐ White ☐ Black/Afr. American ☐ Asian ☐ Amer. Indian/Alaskan ☐ Other ☐ Hawaiian/Pacific Is.	☐ Hispanic/Latino ☐ Not Hispanic/Latino

Street Address	Apt.	City	County	Zip Code	Census Tract	Home Phone	Work Phone
						(___)___-____	(___)___-____

Status: ☐ Suspect; Case: ☐ New ☐ Recurrent ☐ Reopen

Predominant Sites: ☐ Pulmonary ☐ Laryngeal ☐ Other _____

Is Case Married? ☐ Yes ☐ No

Daycare Attendee/Employee? ☐ Yes ☐ No

TST Date __/__/____ mm _____ Positive ☐ Yes ☐ No

Date Treatment Started: __/__/____

IGRA Date __/__/____ Positive ☐ Yes ☐ No

Adherent to Treatment? ☐ Yes ☐ No

CXR Date __/__/____ Reading _____ Cavitary ☐ Yes ☐ No

Dates of Infectious Period __/__/____ To __/__/____

DOT ☐ Yes ☐ No

Source Case: Name: Last, First, Middle ☐ Unknown

Fewer than 3 contacts identified due to: ☐ Patient refused to cooperate ☐ Patient died ☐ Patient lost to follow-up ☐ No contact information available ☐ Other (Specify) _____

Date assistance requested: __/__/____ Name of assistant:

Bacteriology

Specimen	Collection Date	Smear	Culture	Culture ID	Resistant to:

Did patient have contact with livestock or consume unpasteurized dairy? ☐ Yes ☐ No

Identified in prior contact investigation? ☐ Yes ☐ No

Comments:

Priority Criteria

☐ Pos Sputum Smear ☐ Pos Sputum Culture ☐ Cavitary X-Ray ☐ Pulmonary ☐ Laryngeal ☐ Miliary ☐ MDR-TB ☐ Child (<5) ☐ Child (5-<15) ☐ Correctional Facility Inmate ☐ Long term Facility Resident ☐ Recent Convertor

Social Behavioral Risk

☐ 900 Positive ☐ HBV Positive ☐ Excessive alcohol use ☐ Other substance use ☐ Mental Illness ☐ Dementia

B. Interview & Exposure Site Information

Interview Date	Interviewed by: Last Name	First Name:	Clinic:	Date Home/Other Site Visit 1:	Date Home/Other Site Visit 3:
Interview Date (>7 days after)				Date Home/Other Site Visit 2:	Date Home/Other Site Visit 4:
__/__/____				__/__/____	__/__/____

Site #	Site Name	Location	Site Type	Est. # Exposed
1			☐ Airplane/Pub. Transport. ☐ Colonia ☐ Correctional Facility ☐ Daycare ☐ Dorm ☐ Home/Residence ☐ Hospital/Medical ☐ Leisure/Recreation ☐ Nursing Home ☐ Office/Workplace ☐ School/College ☐ Other (Specify):	
2			☐ Airplane/Pub. Transport. ☐ Colonia ☐ Correctional Facility ☐ Daycare ☐ Dorm ☐ Home/Residence ☐ Hospital/Medical ☐ Leisure/Recreation ☐ Nursing Home ☐ Office/Workplace ☐ School/College ☐ Other (Specify):	
3			☐ Airplane/Pub. Transport. ☐ Colonia ☐ Correctional Facility ☐ Daycare ☐ Dorm ☐ Home/Residence ☐ Hospital/Medical ☐ Leisure/Recreation ☐ Nursing Home ☐ Office/Workplace ☐ School/College ☐ Other (Specify):	
4			☐ Airplane/Pub. Transport. ☐ Colonia ☐ Correctional Facility ☐ Daycare ☐ Dorm ☐ Home/Residence ☐ Hospital/Medical ☐ Leisure/Recreation ☐ Nursing Home ☐ Office/Workplace ☐ School/College ☐ Other (Specify):	

Media Involvement? ☐ Yes ☐ No

If yes, media source and contact

TEXAS Department of State Health Services

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Page ___ of ___

Date __ __/__ __/__ __ __ __

Case/Suspect Information

Last Name	First Name	Middle Name	DOB	SSN
			__ __/__ __/__ __ __ __	__ __ __-__ __-__ __ __ __

C. Contact Information

Contact 1

__ __ __-__ __-__ __ __ __ SSN

Last Name First Middle

DOB __ __/__ __/__ __ __ __

Gender ☐ Male ☐ Female Site # _____

Race _____

☐ Hispanic/Latino ☐ Not Hispanic/Latino

Date Identified: __ __/__ __/__ __ __ __

Relation to case:

BCG ☐ Yes ☐ No Date: __ __/__ __/__ __ __ __

Address

City County or Country

Phone #: ☐ Work ☐ Home

Country of Birth (if not US):

Exposure Length
☐ >6 hrs/wk
☐ >2 but <6 hrs/wk
☐ <2 hrs/wk
☐ No contact was made

Exposure Setting
Indoors: ☐ Size of car ☐ Size of bedroom ☐ Size of house ☐ Larger than house
☐ Outdoors

Ongoing exposure? ☐ Yes ☐ No

If no, date last exposure __ __/__ __/__ __ __ __

900 Test Results ☐ Pos ☐ Neg ☐ Unk

Priority (H, M, L):

History of positive TST? ☐ Yes ☐ No

Date __ __/__ __/__ __ __ __

TST/IGRA Date	mm/%	Pos	Neg
__ __/__ __/__ __ __ __	_____	☐	☐
__ __/__ __/__ __ __ __	_____	☐	☐
__ __/__ __/__ __ __ __	_____	☐	☐

CXR Date __ __/__ __/__ __ __ __ ☐ Normal ☐ Abnormal

☐ PA ☐ Lateral ☐ Lordotic ☐ Other

Evaluation Complete? ☐ Yes ☐ No

If No, Reason Not Complete:
☐ Died ☐ Lost to Follow-up ☐ Refused Evaluation ☐ 1st TST not done/read
☐ 2nd TST not done/read ☐ 3rd TST not done/read ☐ No Chest X-Ray

Treatment Recommended? ☐ Yes ☐ No

Reason Treatment not started:
☐ Contraindicated ☐ Died ☐ History of noncompliance ☐ Lost to follow-up ☐ Prior adequate treatment ☐ Refused treatment

ATS Class
☐ 0 ☐ 3 ☐ 1 ☐ 4 ☐ 2 ☐ 5

Treatment Outcome (if recommended)
☐ Completed adequate therapy
☐ Lost/patient not located
☐ Refused (patient chose to stop meds
☐ Refused (patient chose to stop evaluation)
☐ Adverse treatment event
☐ Died
☐ Moved out of state/country
☐ Provider decision-pregnant
☐ Provider decision-other (specify): _____
☐ No further evaluation needed
☐ Active TB developed

Treatment Started: __ __/__ __/__ __ __ __

Treatment Stopped: __ __/__ __/__ __ __ __

Months Recommended: _____

Months RX Completed: _____

Clinic:

Contact 2

__ __ __-__ __-__ __ __ __ SSN

Last Name First Middle

DOB __ __/__ __/__ __ __ __

Gender ☐ Male ☐ Female Site # _____

Race _____

☐ Hispanic/Latino ☐ Not Hispanic/Latino

Date Identified: __ __/__ __/__ __ __ __

Relation to case:

BCG ☐ Yes ☐ No Date: __ __/__ __/__ __ __ __

Address

City County or Country

Phone #: ☐ Work ☐ Home

Country of Birth (if not US):

Exposure Length
☐ >6 hrs/wk
☐ >2 but <6 hrs/wk
☐ <2 hrs/wk
☐ No contact was made

Exposure Setting
Indoors: ☐ Size of car ☐ Size of bedroom ☐ Size of house ☐ Larger than house
☐ Outdoors

Ongoing exposure? ☐ Yes ☐ No

If no, date last exposure __ __/__ __/__ __ __ __

900 Test Results ☐ Pos ☐ Neg ☐ Unk

Priority (H, M, L):

History of positive TST? ☐ Yes ☐ No

Date __ __/__ __/__ __ __ __

TST/IGRA Date	mm/%	Pos	Neg
__ __/__ __/__ __ __ __	_____	☐	☐
__ __/__ __/__ __ __ __	_____	☐	☐
__ __/__ __/__ __ __ __	_____	☐	☐

CXR Date __ __/__ __/__ __ __ __ ☐ Normal ☐ Abnormal

☐ PA ☐ Lateral ☐ Lordotic ☐ Other

Evaluation Complete? ☐ Yes ☐ No

If No, Reason Not Complete:
☐ Died ☐ Lost to Follow-up ☐ Refused Evaluation ☐ 1st TST not done/read
☐ 2nd TST not done/read ☐ 3rd TST not done/read ☐ No Chest X-Ray

Treatment Recommended? ☐ Yes ☐ No

Reason Treatment not started:
☐ Contraindicated ☐ Died ☐ History of noncompliance ☐ Lost to follow-up ☐ Prior adequate treatment ☐ Refused treatment

ATS Class
☐ 0 ☐ 3 ☐ 1 ☐ 4 ☐ 2 ☐ 5

Treatment Outcome (if recommended)
☐ Completed adequate therapy
☐ Lost/patient not located
☐ Refused (patient chose to stop meds
☐ Refused (patient chose to stop evaluation)
☐ Adverse treatment event
☐ Died
☐ Moved out of state/country
☐ Provider decision-pregnant
☐ Provider decision-other (specify): _____
☐ No further evaluation needed
☐ Active TB developed

Treatment Started: __ __/__ __/__ __ __ __

Treatment Stopped: __ __/__ __/__ __ __ __

Months Recommended: _____

Months RX Completed: _____

Clinic:

Contact 3

__ __ __-__ __-__ __ __ __ SSN

Last Name First Middle

DOB __ __/__ __/__ __ __ __

Gender ☐ Male ☐ Female Site # _____

Race _____

☐ Hispanic/Latino ☐ Not Hispanic/Latino

Date Identified: __ __/__ __/__ __ __ __

Relation to case:

BCG ☐ Yes ☐ No Date: __ __/__ __/__ __ __ __

Address

City County or Country

Phone #: ☐ Work ☐ Home

Country of Birth (if not US):

Exposure Length
☐ >6 hrs/wk
☐ >2 but <6 hrs/wk
☐ <2 hrs/wk
☐ No contact was made

Exposure Setting
Indoors: ☐ Size of car ☐ Size of bedroom ☐ Size of house ☐ Larger than house
☐ Outdoors

Ongoing exposure? ☐ Yes ☐ No

If no, date last exposure __ __/__ __/__ __ __ __

900 Test Results ☐ Pos ☐ Neg ☐ Unk

Priority (H, M, L):

History of positive TST? ☐ Yes ☐ No

Date __ __/__ __/__ __ __ __

TST/IGRA Date	mm/%	Pos	Neg
__ __/__ __/__ __ __ __	_____	☐	☐
__ __/__ __/__ __ __ __	_____	☐	☐
__ __/__ __/__ __ __ __	_____	☐	☐

CXR Date __ __/__ __/__ __ __ __ ☐ Normal ☐ Abnormal

☐ PA ☐ Lateral ☐ Lordotic ☐ Other

Evaluation Complete? ☐ Yes ☐ No

If No, Reason Not Complete:
☐ Died ☐ Lost to Follow-up ☐ Refused Evaluation ☐ 1st TST not done/read
☐ 2nd TST not done/read ☐ 3rd TST not done/read ☐ No Chest X-Ray

Treatment Recommended? ☐ Yes ☐ No

Reason Treatment not started:
☐ Contraindicated ☐ Died ☐ History of noncompliance ☐ Lost to follow-up ☐ Prior adequate treatment ☐ Refused treatment

ATS Class
☐ 0 ☐ 3 ☐ 1 ☐ 4 ☐ 2 ☐ 5

Treatment Outcome (if recommended)
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☐ No further evaluation needed
☐ Active TB developed

Treatment Started: __ __/__ __/__ __ __ __

Treatment Stopped: __ __/__ __/__ __ __ __

Months Recommended: _____

Months RX Completed: _____

Clinic: