Instructions for Completing
Tuberculosis Contact Investigation Form

This form is used by public health nurses to guide and document the examination of contacts to active cases of tuberculosis 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 is completed. This should occur **10 business days after the index case is reported to the PHN**. 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. If new contacts are identified or additional screening of previously named contacts has occurred, please provide updated information to the Alaska TB Program as soon as possible.

References on Contact Priorities and Estimating the Infectious Period are available on the back of the forms.

INDEX CASE
Demographics: Self-explanatory
Clinical Status: Indicate the TB site or status, AFB smear and sputum mycobacterial culture results, sensitivities to isoniazid, rifampin, ethambutol, pyrazinamide and streptomycin and start date of TB medications, if known. Estimate the infectious period by using Table 1 on the reverse side of this form.

CONTACTS
Demographics: Name, address, phone, birthdates, sex, race, relation to case, dates of exposure and priority. Determine priority by using Figure 1 on the reverse side of this form.
Prior positive TST/IGRA: If contact has history of (+) TST/IGRA, record date and result.
IGRA: If an interferon gamma release assay (IGRA) was done, record date and result.
Initial and Follow-up TSTs/IGRAs: Record dates and results. Administer follow-up TST 8 -10 weeks after initial negative TST.
Symptom Screening: Record date and symptoms, if any.
Chest X-ray: Record date and results.
Sputum smears: Record dates and results. If cultures are (+), record in comments section.
Treatment History: Indicate if contact has been treated for LTBI or active TB; record start and stop dates.
Reason for Ending Treatment: Indicate reason why treatment was stopped.
*Comments: S*elf explanatory.
Follow-up: Record the date on which follow-up was completed or the contact was lost to follow-up.