Tennessee TB Elimination Program
Contact Investigation Worksheet

Name:_____	**DOB: ____/____/_____**			**Sex:** ☐ Male ☐ Female
Race:	☐ White	☐ Black	☐ Asian	☐ Amer. Indian/Alaskan Native
	☐ Native Hawaiian/Other Pacific Islander			☐ Other_____
Ethnicity	☐ Hispanic			☐ Non-Hispanic
Patient's Home Phone: (_____) _____-_____			**Patient's Home Phone:** (_____) _____-_____	
Street Address: _____				
City: _____	**County:** _____		**Zip:**_____	
Living Situation:	☐ Shelter	☐ Homeless	☐ Jail	☐ Nursing Home
	☐ Other:_____			

Bacteriology Results	AFB smear	☐ Pos	☐ Neg	Culture	☐ Pos	☐ Neg
		☐ Unk	☐ ND		☐ Unk	☐ ND

Site of Disease	☐ Pulmonary	☐ Extrapulmonary	☐ Both
Treatment Start Date _____/_____/_____		**Treatment Start Date** _____/_____/_____	
Date of 1st smear _____/_____/_____		**Date of 1st ABN chest X-ray** _____/_____/_____	
CXR/CT Results	☐ ABN/Cavitary	☐ ABN/Non-cavitary	☐ Abnormal	☐ Normal
Symptoms	☐ Fever	☐ Chills	☐ Night sweats	☐ Wt. loss _____lbs
	☐ Cough	☐ Productive cough	☐ Other_____	
Date of Symptom Onset _____/_____/_____				
Infectious Period _____/_____/_____ to _____/_____/_____				

Case or Suspect Interview

Place of Initial Interview_____	**Interview Date** _____/_____/_____
Interviewer_____	
Interpreter Used? ☐ Yes ☐ No	**Interpreted by**:_____
Place of Re-interview_____	**Interview Date** _____/_____/_____
Interviewer_____	
Interpreter Used? ☐ Yes ☐ No	**Interpreted by**:_____
Date of Home Visit_____/_____/_____	**Interviewer**_____
Interpreter Used? ☐ Yes ☐ No	**Interpreted by**:_____

NOTES:

Congregate Setting Administrator Interview		
Date of Site Visit _____/_____/_____	Location_____	
Person Interviewed: _____	Title_____	
Interviewed by: _____		
Interpreter Used? ☐ Yes ☐ No		
Interpreted by: _____	Phone: (_____) _____-_____	
Notes:		

Congregate Setting Administrator Interview		
Date of Site Visit _____/_____/_____	Location_____	
Person Interviewed: _____	Title_____	
Interviewed by: _____		
Interpreter Used? ☐ Yes ☐ No		
Interpreted by: _____	Phone: (_____) _____-_____	
Notes:		

Congregate Setting Administrator Interview		
Date of Site Visit _____/_____/_____	Location_____	
Person Interviewed: _____	Title_____	
Interviewed by: _____		
Interpreter Used? ☐ Yes ☐ No		
Interpreted by: _____	Phone: (_____) _____-_____	
Notes:		

Congregate Setting Administrator Interview		
Date of Site Visit _____/_____/_____	Location_____	
Person Interviewed: _____	Title_____	
Interviewed by: _____		
Interpreter Used? ☐ Yes ☐ No		
Interpreted by: _____	Phone: (_____) _____-_____	
Notes:		

I. HOME AND FAMILY

Complete this section for each address where the client has lived during the six (6) months prior to starting TB medication. Begin with the most current address.

Physical address	Apt. #	City	Zip
Mailing Address	Apt. #	City	Zip
Length of time at current address		Date Moved In _____/_____/_____	

Other addresses in previous 5 years	Date Moved In	Date Moved Out

With who do you live? ☐ Alone ☐ With others	How many others live at this address (excluding patient)?

How many children live in the home?	Ages 0-5:	Ages 6-14:

Enter name, relationship and exposure risk of persons who reside at the above address and who do not reside at the above address. Circle exposure setting:

1=Size of car 2=Size of a bedroom 3=Size of a house 4= Size larger than a house
Circle exposure time if >6 hours/week

Name	Relationship to Patient	Setting	Exposure Time	Household Member
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N

How many children do you have who do not live at home?_____ (enter names if at risk of exposure)				
Name	Relationship to Patient	Setting	Exposure Time	Household Member
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N

How many people visited your home and stayed overnight during the past 6 months (this could include holidays, birthdays, special events, etc.)?_____ (enter names)				
Name	Relationship to Patient	Setting	Exposure Time	Household Member
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N

How many people lived in the house during the past six (6) months who do not live with you now?_____ (enter names)				
Name	Relationship to Patient	Setting	Exposure Time	Household Member
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N

Does anyone visit you or another member of your household more than 2-3 times per week? ☐ Yes ☐ No (Stays part of the day, but does not stay overnight—enters names)				
Name	Relationship to Patient	Setting	Exposure Time	Household Member
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N

How many relatives do you see on a regular basis? _____	How often do you see them each week? _____
In what other group activities do you participate? _____	☐ Choir ☐ Church/Church group
How many	☐ Other_____
How many children receive childcare in your home? _____	How often (#days/hours) is each child cared for?_____

Date when you or another household member last provided care services in your home? _____/_____/_____ (enter names)

Name	Setting	Exposure Time	Household Member
	1 2 3 4	Y N	Y N
	1 2 3 4	Y N	Y N
	1 2 3 4	Y N	Y N

How many of your children attend day care centers? _____

Who else spends at least 6-8 hours per week with you? ☐ No one ☐ Other people (enter names below)

Name	Relationship to Patient	Setting	Exposure Time	Household Member
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N

With whom do you eat your meals? ☐ Alone ☐ With others (enter names below)

Name	Relationship to Patient	Setting	Exposure Time	Household Member
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N

Have you been around other relatives during the last six (6) months who have not already been named (This could have been for holidays, reunions, etc. Enter names below)				
Name	Relationship to Patient	Setting	Exposure Time	Household Member
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N
		1 2 3 4	Y N	Y N

Did you attend a family gathering or reunion within the past six (6) months? ☐ Yes ☐ No		
Date _____/_____/_____	Location_____	# people_____
Date _____/_____/_____	Location_____	# people_____
Date _____/_____/_____	Location_____	# people_____
When was the last time that you went on vacation or out of town?		
Date left town _____/_____/_____	Date returned _____/_____/_____	
Type of transportation used	☐ Personal vehicle	☐ Public transportation
If public transportation, list _____		
Where did you stay?	☐ Personal residence ☐ Hotel	☐ Other_____
Whom did you visit? _____		
How do you spend your time when you are not working? _____ _____		
With whom do you spend your time with when you are not working? _____		
Have you ever known anyone with tuberculosis?	☐ Yes	☐ No
Who? _____	When? _____	
Comments:		
Does anyone in your home smoke?	☐ Yes ☐ No	# smokers _____
****Complete contact investigation forms for each contact****		

II. DWELLING CHARACTERISTICS

Square feet of home _____ sq. ft.	# bedrooms _____	# bathrooms _____	
List the height of ceiling for each	bedroom(s) _____	bathroom(s) _____	
	living room _____	den_____	kitchen_____
	other _____		
Natural ventilation in home	☐ windows open	☐ doors open	☐ skylights
	☐ other _____		
Fan in home	☐ window fans	☐ ceiling fans	☐ floor fans
	which rooms? _____		
Air conditioner	☐ window units	which rooms? _____	
Central heat and air	☐ Yes ☐ No	how many for home? _____	
	which rooms? _____		
Type of heat _____			
Is there air moving? ☐ Yes ☐ No	Is the air stagnant? ☐ Yes ☐ No		
Physical findings	☐ clean	☐ cluttered	☐ dirty	☐ crowded
Are there pets in the home? ☐ Yes ☐ No	# pets _____		

III. EMPLOYMENT

Document the patient' employment history during the six (6) months prior to starting anti-TB medication beginning with the most recent place of employment. Additional copies of this section may be made for multiple employment settings.

Are you employed? ☐ Yes ☐ No	
If unemployed, how do you support yourself? _____	
Place of employment _____	
Work Address: _____ _____	
Begin date _____/_____/_____	End date _____/_____/_ _____
Shift/hours_____	
Does the patient work swing shifts or overtime on another shift? ☐ Yes ☐ No	
Supervisor's name _____	Phone (_____) _____- _____
Dates of work exposure _____/_____/_____ to _____/_____/_____	
Describe type of work performed: _____ _____	
Describe type of work area (e.g., office, garage, cubicle, shop, warehouse, restaurant, etc.) _____	
Do you work primarily	☐ indoors ☐ outdoors ☐ both
If you work indoors, how many people do you work with (6-8 hrs/week)? _____ or attach list	

Enter name, and exposure risk of persons. Circle exposure setting:

1=Size of car 2=Size of a bedroom 3=Size of a house 4= Size larger than a house
Circle exposure time if >6 hours/week

Name	Setting	Exposure Time
	1 2 3 4	Y N
	1 2 3 4	Y N

	1 2 3 4	Y N
	1 2 3 4	Y N
	1 2 3 4	Y N

Do you travel to work	☐ alone	☐ with others (list above)	
Method of travel to work	☐ car	☐ truck	☐ bus
	☐ other public transportation _____		

Last date traveled to work _____/_____/_____

How many people ride with you during the day? _____

How long do these people ride with you during the day? _____

At work, do you eat ☐ alone ☐ with others (list above)

When at work, where do you eat? _____

Are you in contact with any children while at work? ☐ Yes ☐ No

If yes, how many children? _____ (list names below)

Name	Setting	Exposure Time
	1 2 3 4	Y N
	1 2 3 4	Y N
	1 2 3 4	Y N

How many co-workers do you spend 6-8 hours with per week (who have not already been named)? List names below

Name	Setting	Exposure Time
	1 2 3 4	Y N
	1 2 3 4	Y N
	1 2 3 4	Y N

Have you been out sick from work? ☐ Yes ☐ No

If yes, list date(s) below

_____/_____/_____ to _____/_____/_____

_____/_____/_____ to _____/_____/_____

_____/_____/_____ to _____/_____/_____

Worksite Characteristics: OBTAIN COPY OF FLOOR PLANS WITH DUCTING				
Name of building engineer or maintenance supervisor _____				
Was this person present during the site visit? ☐ Yes ☐ No				
Work hours of each shift _____				
Total # of employees at the facility _____				
Total # of employees in patient's work area _____				
Total # of employees on each shift _____				
Total # of floor in building _____				
# of floors serviced by each HVAC system _____				
Were HVAC units on during infectious period? ☐ Yes ☐ No				
Proportion of air re-circulated in facility _____	% of outside air _____			
Location of supply air register _____	Operational ☐ Yes ☐ No			
Hours of fan operation _____				
Location of fans	☐ one wall	☐ adjacent	☐ opposing walls	☐ 3 sides
	☐ 4 sides	☐ other _____		
# of windows located in work area _____				
During work hours are windows	☐ open	☐ closed		
Location of windows	☐ one wall	☐ adjacent	☐ opposing walls	☐ 3 sides
	☐ 4 sides	☐ other _____		
# of doors located in work area _____				
During work hours are windows	☐ open	☐ closed		
# of shipping/loading dock doors in work area _____				
Are they used during work hours	☐ yes	☐ no		
Location	☐ one wall	☐ adjacent	☐ opposing walls	☐ 3 sides
	☐ 4 sides	☐ other _____		
Square footage of the facility _____	Ceiling height of facility _____			
Square footage of work area _____	Ceiling height of work area _____			
Any cross ventilation in work area ☐ Yes ☐ No				
# of break rooms in work area _____	Square footage of each break area_____			
Ceiling height of each break area _____	# tables/chairs in each break room _____			
Any cross ventilation in the break room(s) ☐ Yes ☐ No				
Where do employees smoke?_____				
Notes:				

IV. SCHOOL

Complete this section for each school the client has attended during the six (6) months prior to starting TB medication beginning with the most current school. Additional copies of this section may be made for multiple school settings.

Name of school _____		
Address _____		
Index case relationship to this site ☐ student ☐ volunteer ☐ employee		
If an employee, list job title _____		
If student list:	Grade _____	Teacher/homeroom teacher _____
Length of time at school _____/_____/_____ to _____/_____/_____		
Last date of exposure at school _____/_____/_____		
Comments:		
What transportation do you use to get to and from school? ☐ bus ☐ personal vehicle		
If bus, how many other riders _____ (list names below)	If personal vehicle, how many riders _____ (list names below)	
How long is the ride to school? _____	How long is the ride from school? _____	
Do you move from classroom to classroom during the day? ☐ Yes ☐ No (If client moves from classroom to classroom, obtain class schedule and record in Notes)		
With whom do you spend most time with at school? Enter name, and exposure risk of persons. Circle exposure setting: **1=Size of car 2=Size of a bedroom 3=Size of a house 4= Size larger than a house** **Circle exposure time if >6 hours/week**		

Name	Setting	Exposure Time
	1 2 3 4	Y N
	1 2 3 4	Y N
	1 2 3 4	Y N
	1 2 3 4	Y N

Do you participate in any school groups/activities/sports? ☐ Yes ☐ No	
If yes, what	
How often? _____	With who? (list in Notes section)
How do you spend your time after school?	

Is testing for TB infection of classmates indicated? ☐ Yes ☐ No Comments:
Is testing for TB infection of teachers/school personnel indicated? ☐ Yes ☐ No Comments:

School Characteristics (Obtain copy of floor plans with ducting)

Room	Sq. ft.	Ceiling height	Open windows Y/N	Cross ventilation Y/N	Central H&A Y/N	Window AC units Y/N	% fresh air	% re-circulated air	Other
Gymnasium									
Lecture hall									
Locker room									
Office									
Auditorium									
Cafeteria									
Library									
Other:									
Other:									
Classroom	**Sq. ft.**	**Ceiling height**	**Open windows Y/N**	**Cross ventilation Y/N**	**Central H&A Y/N**	**Window AC units Y/N**	**% fresh air**	**% re-circulated air**	**Other**
Homeroom									
1st period									
2nd period									
3rd period									
4th period									
5th period									
6th period									
7th period									
8th period									
Notes:									

V. MEDICAL FACILTIES

Complete this section for each hospital or medical facility/clinic where the client has spent a significant amount of time on a regular basis during the infectious period. Additional copies of this section may be made for multiple school settings.

List clinic or medical office visits during the infectious period:

Name of clinic/office _____

Address _____

Contact name at facility _____ Phone (_____) _____-_____

Date of Visit	Time In	Time Out	# patient in office during this time	# staff exposed on this date
	am/pm	am/pm		
	am/pm	am/pm		
	am/pm	am/pm		
	am/pm	am/pm		

Rooms	Sq. Ft.	Ceiling Ht.	Ventilation (windows, fans, etc.)	Central H&A units Y/N	% fresh air vs. re-circulated air
Waiting room					
Exam room					
Other					
Other					
Other					
Notes					

Hospital Characteristics

Did you visit an emergency room in the last three (3) months? ☐ Yes ☐ No

Were you transported by? ☐ Ambulance ☐ Personal vehicle

If by personal vehicle, who transported you? _____

Were you admitted overnight? ☐ Yes ☐ No

Name of hospital _____

Date of Visit	Length of Stay in ER Waiting Room

Were you admitted to the hospital? ☐ Yes ☐ No

Date of Admission	Date of Discharge

Did another patient share your hospital room? ☐ Yes ☐ No

If yes, name of patient(s) _____

Did the hospital workers wear a mask when they entered your room? ☐ Yes ☐ No

Did visitors wear a mask when they entered your room? ☐ Yes ☐ No

Mark all that apply:

Area	Patient wore mask Y/N	Patient on ventilator Y/N	Aerosol generating procedures Y/N	Date(s) in area	Time in area	Time out of area	ACH of area	Type of pressure neg./pos.	# staff exposed
Emergency room									
Admitting office									
PT dept.									
Radiology									
Laboratory									
Pathology									
Semi-private room									
Ward									
Surgery									
Recovery room									
Holding room									
Labor/delivery									
Nursery									
Exam room									
Waiting room									
Waiting room									
Other:									
Other:									
Notes:									

VI. OTHER SITES OF POTENTIAL EXPOSURE

Complete this section for each address where the client has spent a significant amount of time on a regular basis during the infectious period.

Place	Schedule (days/hrs)	# staff/others on site	Mode of transportation to/from site	Ventilation (windows, fans, etc.)	Sq. ft.	Ceiling height	# H&A units	% fresh air vs. re-circulated air	Smoking inside Y/N
Friend's home									
Family's home									
Bars/nightclubs									
Pool hall/arcade									
Place of worship									
Library									
Dance facility									
Indoor sports arena or event									
Gymnasium/athletic club									
Organization meeting (AA, Masons, garden club, etc.)									
Shelter/homeless soup kitchen									
Shopping trip(s)									
Weekend trip(s)									
School event									
Music event									
Wedding/reception									
Volunteer service(s)									

Names of Other Sites of Potential Exposure	Address of Other Sites of Potential Exposure

What transportation do you use to get to and from each site?

Names of Other Sites of Potential Exposure	Mode of Transportation to and from Site

How many hours do you spend indoors at each site on a weekly basis?

Names of Other Sites of Potential Exposure	# Hours Indoors at Site

Describe the normal activities at each site.

Names of Other Sites of Potential Exposure	# Hours Indoors at Site

With whom do you spend most time with while at the above sites?
Enter name, and exposure risk of persons. Circle exposure setting:

1=Size of car 2=Size of a bedroom 3=Size of a house 4= Size larger than a house
Circle exposure time if >6 hours/week

Name	Setting	Exposure Time
	1 2 3 4	Y N
	1 2 3 4	Y N
	1 2 3 4	Y N
	1 2 3 4	Y N

Is testing for TB infection of contacts at these sites recommended?

Names of Other Sites of Potential Exposure	**Is Testing for TB Infection of Contacts at this Site Recommended? (Y/N)**

Notes:

VII. TRAVEL HISTORY

1. Did the patient travel during the infectious period? ☐ Yes ☐ No (if no, skip travel history section).

2. Type of travel event
   ☐ Business ☐ Pleasure ☐ Family visit ☐ Wedding
   ☐ Reception ☐ Family reunion ☐ Holiday ☐ Other
   If other, please describe
   _____
   _____

3. Travel dates
   _____/_____/_____ to _____/_____/_____

   _____/_____/_____ to _____/_____/_____

   _____/_____/_____ to _____/_____/_____

4. Describe place or destination of travel event
   _____
   _____

5. Place/location of departure _____

6. Date and time of departure _____/_____/_____ at _____am/pm

7. Place/location of arrival _____

8. Date and time of arrival _____/_____/_____ at _____am/pm

9. Did you share a vehicle with friends, family on outings, for doctor's appointments, trips, dining events, etc. during the infectious period? ☐ Yes ☐ No
   If yes, please complete the following:

With Whom	Date (mm/dd/yyyy)	From:	To:	Length of Time

Team discussion and findings concerning risk of disease transmission at this site:

_____
_____
_____
_____

10. Travel method: ☐ Public transportation ☐ Private vehicle
    If public transportation, type of public transportation:
    ☐ Bus ☐ Train ☐ Airplane ☐ Taxi
    ☐ Ship

<u>If by bus:</u>
Name of carrier _____

Team discussion and findings concerning risk of disease transmission at this site:

_____
_____
_____
_____

If by plane:

Name of carrier	
Airport(s) departed from (include layovers)	
Airport(s) arrived at (include layovers)	
Departing route/flight #s	Returning route/flight #s

Team discussion and findings concerning risk of disease transmission at this site:

_____
_____
_____
_____

If by ship/boat:

Name of carrier
Place/location of departure
Date and time of departure _____/_____/_____ at _____am/pm
Place/location of arrival
Date and time of arrival _____/_____/_____ at _____am/pm

Team discussion and findings concerning risk of disease transmission at this site:

_____
_____
_____
_____

Places of Travel in Past Two (2) Years to Countries Where TB is Common

Date Arrived	Date Departed	Country Visited

Contact Investigation Worksheet Notes and Comments

Date	Notes

Plan of Investigation

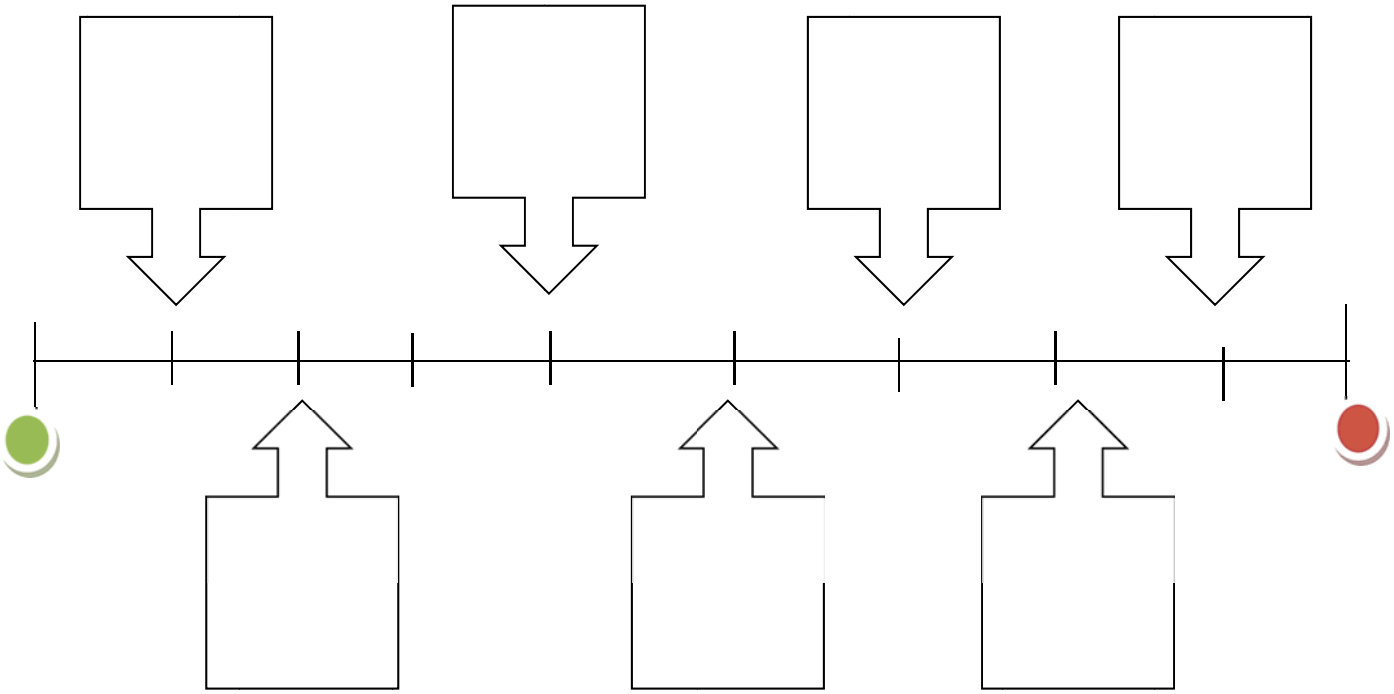
Site of Investigation (place and address)	Exposure Date(s) (dates of last known exposure)	Initial TST or IGRA Dates	2nd TST or IGRA Dates (8-10 weeks from last date of exposure)	To Do List

Timeline

Patient Name:_____ DOB:_____

Date Diagnosed as Suspect/Case:_____Type:_____

Working Infectious Period:_____



Start of Infectious Period

Diagnosed as TB Suspect/Case

TB Medications Started

End of Infectious Period