

Tuberculosis Disease Case Interview Guide

This optional form contains the TB case elements which should be entered in the Orpheus case report and questions to help elicit contacts. It is designed to assist with patient interviews in the field.

LPHA CASE MANAGER _____
 TREATING PHYSICIAN _____

INTERVIEW DATE
 ___/___/___

CASE IDENTIFICATION

Last Name _____ First Name _____ MI _____

Phone(1) _____ Phone(2) _____

Address _____
street city zip

Name of institution, if applicable (e.g. correctional facility, homeless shelter, nursing home) _____

DEMOGRAPHICS

SEX

- Male
 Female

If female

PREGNANT

- No
 Yes

Due date _____

DATE OF BIRTH

___/___/___

COUNTRY OF BIRTH

- US US Territory _____
 Other _____

Date of entry to US ___/___/___
(MM/YYYY)

First language _____

Preferred Language _____

PRIMARY OCCUPATION IN LAST 12 MONTHS

Worksite: _____

- Correctional worker Other employment _____
 Health care worker Unemployed
 Migrant worker Retired
 Not seeking employment (eg student, disabled, homemaker)

If not seeking, reason: _____

Unknown

HEALTH INSURANCE? Yes No

If yes, list health plan: _____

FOR PEDIATRIC TB (age <15)

Lived outside US >2 months? Yes No Unk

If yes, where: _____

Country of birth of guardian 1: _____

Country of birth of guardian 2: _____

DECEASED AT DIAGNOSIS? Yes No

If yes, DATE OF DEATH ___/___/___

CAUSE OF DEATH

- RELATED TO DISEASE UNRELATED TO DISEASE
 UNRELATED TO TREATMENT UNKNOWN

RACE & ETHNICITY (REALD CATEGORIES)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> White |
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Eastern European |
| <input type="checkbox"/> Alaska Native | <input type="checkbox"/> Chinese | <input type="checkbox"/> Micronesian | <input type="checkbox"/> Slavic |
| <input type="checkbox"/> Canadian Inuit, Metis, or First Nation | <input type="checkbox"/> Filipino/a | <input type="checkbox"/> Marshallese | <input type="checkbox"/> Western European |
| <input type="checkbox"/> Indigenous Mexican, Central American, or South American | <input type="checkbox"/> Hmong | <input type="checkbox"/> Chuukese | <input type="checkbox"/> Other White |
| | <input type="checkbox"/> Japanese | <input type="checkbox"/> Other | |
| <input type="checkbox"/> Hispanic or Latino/a | <input type="checkbox"/> Korean | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Other Categories |
| <input type="checkbox"/> Hispanic or Latino Central American | <input type="checkbox"/> Laotian | <input type="checkbox"/> Samoan | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Hispanic or Latino Mexican | <input type="checkbox"/> South Asian | <input type="checkbox"/> Tongan | |
| <input type="checkbox"/> Hispanic or Latino South American | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> Don't know/Unknown |
| <input type="checkbox"/> Other Hispanic or Latino | <input type="checkbox"/> Other Asian | | <input type="checkbox"/> Decline/refuse |
| <input type="checkbox"/> Black or African American | | <input type="checkbox"/> Middle Eastern/North African | |
| <input type="checkbox"/> African American | <input type="checkbox"/> Caribbean (Black) | <input type="checkbox"/> Northern African | |
| <input type="checkbox"/> African (Black) | <input type="checkbox"/> Other Black | <input type="checkbox"/> Middle Eastern | |

BASIS OF DIAGNOSIS

SITE OF DISEASE (check all that apply)

- Pulmonary
- Pleural
- Lymphatic
 - Cervical
 - Intrathoracic
 - Axillary
 - Other lymph _____
- Other _____

SYMPTOMATIC?

- Yes No Unk
 If yes, ONSET on ___/___/___

SYMPTOMS:

- Cough (duration _____) Yes No Unk
- Hemoptysis Yes No Unk
- Fever Yes No Unk
- Night sweats Yes No Unk
- Weight loss _____lbs Yes No Unk
- _____ Yes No Unk

Medical care for symptoms first sought on ___/___/___

Where? _____

Primary reason for evaluation:

- TB Symptoms
- Contact investigation
- Targeted testing
- Employment/Admin screening HCW? Yes No Unk
- Immigration exam
- Incidental abnormal CXR/CT
- Incidental lab result
- Other _____

TB RISKS

TB HISTORY

- Previous diagnosis of TB disease? Yes No Unk If yes, year _____ Was treatment completed? _____ If yes, where _____
 Previous treatment for LTBI? Yes No Unk If yes, year _____ Was treatment completed? _____ If yes, where _____

CONGREGATE SETTINGS

- Homeless in the past year? Yes No Unk _____
- History of homelessness? Yes No Unk Describe _____
- Resident of correctional facility at diagnosis? Yes No Unk If yes, where _____
- History of incarceration? Yes No Unk If yes, when and where _____
- Resident of longterm care facility at diagnosis? Yes No Unk If yes, where _____

SOCIAL FACTORS

- Excess alcohol use in the past year? Yes No Unk IV drug use in the past year? Yes No Unk
- Currently smoking* tobacco? Yes No Unk Non-IV drug use in the past year? Yes No Unk
- Tobacco type (cigarette, cigar, pipe) _____ Amount per day _____ Start year _____
- If not currently smoking, past tobacco smoking*? Yes No Unk Tobacco type _____ Amount per day _____ Start year _____
- Travel outside the US longer than 30 days? Yes No Unk If yes, when and where _____

* >100 cigarettes or equivalent amount in lifetime

MEDICAL AND OTHER RISK FACTORS (select all that apply)

- Diabetes
- Immunosuppressive therapy
- TNF α antagonist therapy
- End stage renal disease
- Post organ transplant
- Weight <90% of ideal body weight
- Cancer/malignancy
- Other _____

Previous contact to an infectious TB patient? Yes No Unk
 If yes, year _____ MDR? _____ Name of case _____

ASSESSMENT OF CASE'S INFECTIOUSNESS

Check (x) each of the following that applies to this case:

Characteristics of Case	Risk of Transmission	Action Needed
<input type="checkbox"/> Laryngeal <input type="checkbox"/> Pulmonary smear positive <input type="checkbox"/> Pulmonary cavitory disease	Highly Infectious	Complete the remainder of this form to identify contacts to be evaluated with skin or blood test
<input type="checkbox"/> Pulmonary smear negative with no cavities <input type="checkbox"/> Extrapulmonary with draining skin lesions	Potentially Infectious	
<input type="checkbox"/> Extrapulmonary with no draining skin lesions or pulmonary involvement	Not Infectious	Evaluate close contacts only

IDENTIFICATION OF POTENTIAL CONTACTS

When evaluating contacts, consider air flow/ventilation, time spent with and proximity to the case, and type of activity spent with case. Persons identified as high risk, especially children, should be evaluated first with TST or IGRA test.

TB Contact Exposure Limits

- ≥ 4 cumulative hours in a small, poorly ventilated space such as a car or enclosed room
- ≥ 8 cumulative hours in a small, well-ventilated space such as an apartment
- ≥ 12 cumulative hours in a large space such as a classroom or house
- ≥ 50 cumulative hours in a large open area such as an auditorium or church

Determine the appropriate TST or IGRA test strategy for each of the groups listed below

I. CLOSE CONTACTS

Persons identified as close contacts should be included in the first group of TST or IGRA testing.

Use Contact Investigation form to list contacts and determine level of risk.

A. Where did the case reside during the infectious period? (check all that apply)

Location	Specify name of facility, address, dates of occupancy
<input type="checkbox"/> Single family dwelling <input type="checkbox"/> Apartment <input type="checkbox"/> Nursing Home or Long-term care facility <input type="checkbox"/> Jail <input type="checkbox"/> Shelter <input type="checkbox"/> Other (specify) _____	

B. Are any case contacts in the following categories?

- Persons who share the same living space Yes No
- Regular overnight visitors (adults or children) Yes No

Comments:

List all contacts on Contact Investigation Form

II. WORKPLACE CONTACTS

Workplace contacts should be considered for evaluation if the case is highly infectious and/or the amount of contact is comparable to a close contact and/or the group is known to be highly immunocompromised (e.g., hospital or daycare). Otherwise, workplace contacts should be included in a second group of TST or IGRA testing if close contacts are skin or blood test positive. Contact TB-OHA for consultation if needed.

A. General description of work activities:

B. Work setting

- Indoor: works in one area Indoor: Works in more than one area Outdoor

Describe indoor work setting: _____

C. Risk categories of workplace contacts

	No Such Contacts	1st round Testing	Consider for Subsequent Testing	Comments
Persons who on a regular basis share room in which case works	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Persons who share lunch, break, or other work time with case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Persons who share transportation with case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

III. OTHER

Has the case traveled internationally by air in the past 6 months? (If yes, contact TB-OHA)
 Yes Date(s) _____ Countries visited _____
 No Length of flight(s) _____ Length of visit _____

Was the case transported by an EMT?
 Yes Date _____ Describe _____
 No

Is the case enrolled in a school, university, or daycare?
 Yes Name of school _____ Hours/week in school _____
 No

Does the case attend church or other faith community on a regular basis?
 Yes Name of church _____
 No If yes, does the case participate in group religious activities in a small, closed space? Yes No

Does the case participate in group sport activities?
 Yes Specify _____
 No

Does the case participate in any other social groups, committees, clubs, or organizations?
 Yes Specify _____
 No

Does the case spend time with relatives or friends outside the home?
 Yes Hours/week _____
 No

Where does the case spend significant amounts of leisure time? _____

If the case drinks alcohol, where are his/her typical drinking places? _____