

Place Client ID Label Here

# Contact Screening Parameters Tool

## INSTRUCTIONS

This tool has been adapted from Toronto Public Health and provides the **MINIMUM guidance for INITIAL follow-up** of contacts of infectious tuberculosis (TB) cases. Contact investigation outcomes must be assessed for all settings to decide if contact follow-up should be expanded contingent on the resources available. Cumulative hour thresholds are *guidelines*, not absolute and should be tailored to each investigation to account for risk versus available resources.

**NOTE:** If variations to parameters exist, media attention is expected, and/or cases spent time in school, daycare, long-term care, shelters/corrections, or high risk facilities (e.g., hospital settings), an *immediate discussion* with a Population and Public Health (PPH) TB Coordinator (community setting) or an Infection Control Professional (ICP) (hospital setting) is required.

Definitions and Considerations	
Cumulative exposure	Total number of hours during the case's period of infectivity that contacts shared the same airspace with the case (and contact did not use an N95 respirator). In facility settings, contacts may include direct care and support staff, volunteers, visitors
Period of infectivity (POI)	Calculate start of infectivity by counting back from TB symptom onset or date of first test indicating TB, whichever is first, as below: <ul style="list-style-type: none"> <li>• Smear negative and chest x-ray (CXR) normal/non-cavitary: 4 weeks</li> <li>• Smear positive and CXR normal/non-cavitary: 8 weeks</li> <li>• Smear negative and CXR cavitary: 8 weeks</li> <li>• Smear positive and CXR cavitary: 12 weeks</li> </ul> POI normally ends on the date the case is placed on Airborne Precautions. See Break in Contact (below)
Break in contact (BIC)	The last date a contact was exposed to an active infectious TB case (e.g., last day at work/school, date placed under Airborne Precautions in hospital). Repeat TST is done at least 8 weeks after BIC. BIC may vary in different settings; <ul style="list-style-type: none"> <li>• For cases on home isolation with fully sensitive TB (or INH resistant only), for household contacts <math>\geq 5</math> years use BIC:               <ul style="list-style-type: none"> <li>◦ For smear negative: 2 weeks on effective treatment</li> <li>◦ For smear positive: 4 weeks on effective treatment OR date of smear conversion, whichever first</li> </ul> </li> <li>• For household contacts &lt;5 years old, when case is on home isolation, the BIC is the date case is no longer infectious</li> </ul>
Effective TB treatment (in relation to BIC)	<ul style="list-style-type: none"> <li>• Standard anti-tuberculin treatment (or as appropriate for known drug sensitivities) has begun (RIPE treatment)</li> <li>• There is evidence of clinical improvement</li> <li>• The individual is toleration medication with no breaks in treatment</li> <li>• If individual is also smear positive repeat sputum smears will show evidence of declining</li> </ul>
Initial & repeat tuberculin skin test (TST)	Assess all contacts for TB signs and symptoms when doing a skin test. The initial tuberculin skin test should be done as soon as possible, then repeated $\geq 8$ weeks after BIC date
Ventilation	If number of air changes per hour (ACH) is available, 6 or more ACH is considered good ventilation; below 2 ACH is considered poor ventilation. In poorly ventilated spaces, consider lowering threshold for exposure time, e.g., a small room with radiator/baseboard heating, no forced air, and no open windows. Consider direction/path of air flow (e.g., fan blowing air from infectious patient towards others; basement apartment in a house with forced air furnace - air recirculates through entire house)
Clinical pulmonary case	(a) Radiology suggestive of active pulmonary TB <b>AND</b> culture negative on respiratory sample (or no laboratory specimens available) <b>OR</b> (b) PCR positive on lung biopsy. If deceased and no specimens will be available, clinical consultation may be necessary to determine the working classification of the case
Pleural TB	If sputum/bronchoalveolar lavage (BAL) is culture positive, manage as pulmonary case. If radiology indicates pulmonary involvement (e.g., infiltrates, cavities) but sputum/BAL cultures are negative, manage as clinical pulmonary case. If radiology does not indicate pulmonary involvement and sputum/BAL cultures are negative, manage as extrapulmonary – no contact follow-up required
TB wounds (smear <u>and</u> culture positive tissue/fluid from surgical wounds, abscesses)	Diseased tissues are not normally sources of infection, unless procedures create aerosols. Staff involved in high pressure irrigation of open TB wounds, orthopaedic procedures (i.e., cutting with power tools) or cauterization of TB infected tissue while not wearing a N95 respirator shall be screened. Staff involved in dressing changes with or without packing, but no irrigation, DO NOT need contact screening. Autopsy and embalming have also been associated with TB transmission; staff not using an N95 respirator during these procedures on a deceased untreated TB case shall be screened
Aerosol-Generating Medical Procedure (AGMP)	Aerosol-generating medical procedures (AGMPs) are medical procedures that can generate aerosols as a result of artificial manipulation of a person's airway. There are several types of AGMPs which have been associated with a documented increased risk of tuberculosis (TB) or SARS transmission: <ul style="list-style-type: none"> <li>• Intubation and related procedures (e.g., manual ventilation, open endotracheal suctioning)</li> <li>• Cardiopulmonary resuscitation</li> <li>• Bronchoscopy</li> <li>• Sputum induction</li> <li>• Nebulized therapy</li> <li>• Autopsy</li> <li>• Non-invasive positive pressure ventilation (CPAP, BiPAP)</li> </ul> There is debate whether other medical procedures may result in the generation of aerosols through cough induction and lead to transmission of infection. However, to date there is no evidence of the transmission of respiratory infections, including TB, SARS or influenza, by these methods. Examples of these procedures include: <ul style="list-style-type: none"> <li>• High-frequency oscillatory ventilation</li> <li>• Tracheostomy care</li> <li>• Chest physiotherapy</li> <li>• Obtaining nasopharyngeal swabs or aspirates</li> </ul> Note: Irrigation of a wound / cavity or joint of a patient with suspected or confirmed non-respiratory TB has also been associated with an increased risk of TB transmission. Staff present during the procedure without an N95 respirator to be considered at risk
Contacts < 1 year of age	Start with minimum guideline for contacts <5 years old and consider lowering threshold based on closeness of exposure (e.g., index case held baby while infectious)

Elderly contacts	For community-living contacts 85 years or older in addition to symptom screening, collect a chest x-ray rather than a TST. For long-term care contacts, see section 3 below
Immunocompromised contacts	Refers to patients with congenital or acquired immunodeficiency or immunodeficiency due to therapeutic agents or hematologic malignancies. E.g., individuals who are HIV positive with low CD4 counts; dialysis, oncology, and transplant patients Consider lowering threshold based on extent of immunosuppression and closeness of exposure (e.g., direct caregivers). Consider symptom assessment and chest x-ray with or without TST, and flag TB exposure in the client's hospital/physician chart.
High Risk Facility*	Facility classification should precede investigation to determine the breadth of scope necessary for investigation. High risk facilities are considered as: <ul style="list-style-type: none"> <li>Hospitals and hybrid long term care centers with &gt; 200 beds and &gt; 6 active TB cases present annually</li> <li>Hospitals and hybrid long term care centers with &lt; 200 beds and &gt; 3 active TB cases present annually</li> <li>Long-term care institutions including homes for the aged, nursing homes, chronic care facilities, hospices, retirement homes, designated assisted living centers, and any other collective living centers with <u>≥</u> 3 active TB cases present annually</li> </ul>
RIPE	The abbreviation of standard treatment for all patients with active TB in Canada; a regimen of isoniazid (INH), rifampin (RMP), pyrazinamide (PZA) and ethambutol (EMB) initially
Tuberculin Skin Test (TST)	Skin test to identify whether a person has delayed-type hypersensitivity reaction to tuberculin antigens Note: This test is not helpful in diagnosis of active TB and can have a false negative result in advanced active disease and/or immunocompromised patients

\* NOTE: The Canadian Tuberculosis Standards (7<sup>th</sup> edition) do not use this terminology. Rather, they consider health care settings either “Low Risk” or “Not Low Risk”

### 1. Assess Case Level of Infectivity (LOI)

- Extrapulmonary cases:** where pulmonary involvement has been ruled out and there has not been wound care/ irrigation of wound with MTB, no contact follow-up required.
- Source case investigation:**
  - Only indicated for children less than 5 years of age
  - Child cases <10 years of age** are rarely infectious; contact follow-up only required if cavitary disease or smear positive sputum/ gastric lavage
- Clinical pulmonary TB cases:** only screen household contacts.
- Laryngeal TB cases:** score as High Risk regardless of smear/chest x-ray score. If also pulmonary involvement decrease the threshold for exposure time to include a broader group of contacts.
- For **all other pulmonary TB cases:** score level of infectivity rating by adding highest smear count (from sputum, BAL, or gastric aspirate specimens) and chest x-ray results:

<p><b>Check all that apply:</b></p> <p><input type="radio"/> Pulmonary → proceed to level of infectivity rating</p> <p><input type="radio"/> Clinical pulmonary → proceed to section 3</p> <p><input type="radio"/> Extrapulmonary (wound care only) → proceed to bottom of page 2</p> <p><input type="radio"/> Extrapulmonary (no pulmonary involvement, no wound care) → stop here</p>	<p><b>Circle smear and chest x-ray score; then add scores for level of infectivity rating:</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;"><b>HIGHEST SMEAR</b></td> <td style="width: 50%;">Negative/Not applicable</td> <td style="width: 10%; text-align: right;">0</td> <td style="width: 20%;"></td> </tr> <tr> <td></td> <td>Scarce/Moderate (few, 1+, 2+)</td> <td style="text-align: right;">1</td> <td></td> </tr> <tr> <td></td> <td>Numerous (3+, 4+)</td> <td style="text-align: right;">2</td> <td></td> </tr> <tr> <td></td> <td><i>plus</i></td> <td></td> <td></td> </tr> <tr> <td><b>CHEST X-RAY REPORT FINDING</b></td> <td>Normal/Calcified granuloma</td> <td style="text-align: right;">0</td> <td></td> </tr> <tr> <td></td> <td>Infiltrates/Opacities/Fibronodular densities</td> <td style="text-align: right;">1</td> <td></td> </tr> <tr> <td></td> <td>Cavitation</td> <td style="text-align: right;">2</td> <td></td> </tr> <tr> <td><b>LEVEL OF INFECTIVITY RATING</b></td> <td></td> <td style="text-align: right;">=</td> <td></td> </tr> <tr> <td colspan="2" style="border-top: 1px solid black;"></td> <td></td> <td></td> </tr> </table>	<b>HIGHEST SMEAR</b>	Negative/Not applicable	0			Scarce/Moderate (few, 1+, 2+)	1			Numerous (3+, 4+)	2			<i>plus</i>			<b>CHEST X-RAY REPORT FINDING</b>	Normal/Calcified granuloma	0			Infiltrates/Opacities/Fibronodular densities	1			Cavitation	2		<b>LEVEL OF INFECTIVITY RATING</b>		=						<p><b>Risk Level</b></p> <p>0 .....Low</p> <p>1 .....Low</p> <p>2 .....Low</p> <p>3 .....High</p> <p>4 .....High</p>
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## 2. Establish Case Period of Infectivity (POI)

<b>Beginning of Infectiousness</b> yyyy/mm/dd:	<b>Date and Time Airborne Precautions Instituted</b> yyyy/mm/dd:	<b>Treatment Start Date</b> yyyy/mm/dd:
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## 3. Identify Contacts Requiring Follow-up and Establish Break In Contact – please complete the following:

Location of Exposure	Low Risk (0 – 2)	High Risk (3 – 4)	Contacts meeting criteria?		Facility	BIC
			No	Yes		
<b>Household</b>	<ul style="list-style-type: none"> <li>Everyone in household – <i>initial &amp; repeat TST</i></li> <li>For rooming houses/basement apartments, consider those on the same floor as "household"</li> </ul>	<ul style="list-style-type: none"> <li>Everyone in household – <i>initial &amp; repeat TST</i></li> <li>For rooming houses/basement apartments with forced air, consider all floors as "household"</li> </ul>	No	Yes		
<b>Close non-household</b> (e.g. family, friends)	<ul style="list-style-type: none"> <li>Contacts ≥ 5 years old with ≥ <b>120 hours</b> cumulative exposure – <i>initial &amp; repeat TST</i></li> <li>Contacts &lt; 5 years old or immunosuppressed contacts with ≥ <b>60 hours</b> cumulative exposure – <i>initial &amp; repeat TST</i></li> </ul>	<ul style="list-style-type: none"> <li>Contacts ≥ 5 years old with ≥ <b>96 hours</b> cumulative exposure – <i>initial &amp; repeat TST</i></li> <li>Contacts &lt; 5 years old or immunosuppressed contacts with ≥ <b>36 hours</b> cumulative exposure – <i>initial &amp; repeat TST</i></li> </ul>	No	Yes		
<b>Worksites/ Universities/ Colleges</b>	<ul style="list-style-type: none"> <li>Smear negative index case – <i>no screening</i></li> <li>Smear positive index case – follow-up contacts with ≥ <b>120 hours</b> of cumulative exposure in a poorly ventilated or small space (e.g., ~ 150 square feet) – <i>TST &gt; 8 weeks BIC</i></li> </ul>	<ul style="list-style-type: none"> <li>Contacts with ≥ <b>96 hours</b> of cumulative exposure in a medium space (e.g., classroom or smaller size space), or within 8 feet of index case in a large space (e.g., lecture hall, large open warehouse or open office floor) – <i>TST &gt; 8 weeks BIC</i></li> <li>Lower threshold for poorly ventilated or small space (e.g., lunch room, ~ 150 square feet)</li> </ul>	No	Yes		
<b>School Contacts ≥ 5 years of age</b> <small>(excludes universities/ colleges)</small>	<ul style="list-style-type: none"> <li>Smear negative index case – <i>no screening</i></li> <li>Smear positive index case – follow-up contacts with ≥ <b>120 hours</b> of cumulative exposure in classroom and group activities – <i>initial &amp; repeat TST</i></li> </ul>	<ul style="list-style-type: none"> <li>Contacts with ≥ <b>96 hours</b> of cumulative exposure in classroom and group activities – <i>initial &amp; repeat TST</i></li> </ul>	No	Yes		
<b>Daycare/ School Contacts &lt; 5 years of age</b>	<ul style="list-style-type: none"> <li>Contacts &lt; 5 years old with ≥ <b>60 hours</b> cumulative exposure – <i>initial &amp; repeat TST</i></li> <li>Staff/volunteers with ≥ <b>120 hours</b> cumulative exposure – <i>initial &amp; repeat TST</i></li> </ul>	<ul style="list-style-type: none"> <li>Contacts &lt; 5 years old with ≥ <b>36 hours</b> cumulative exposure – <i>initial &amp; repeat TST</i></li> <li>Staff/volunteers with ≥ <b>96 hours</b> cumulative exposure – <i>initial &amp; repeat TST</i></li> </ul>	No	Yes		
<b>Shelters/ Group Homes/ Drop-ins</b>	<ul style="list-style-type: none"> <li>Contacts ≥ 5 years old who spent ≥ <b>5 nights</b> sleeping in the same room – <i>TST &gt; 8 weeks BIC</i></li> <li>Staff and others with ≥ <b>120 hours</b> cumulative exposure – <i>TST &gt; 8 weeks BIC</i></li> <li>Contacts &lt; 5 years old or immunosuppressed contacts with ≥ <b>60 hours</b> cumulative exposure – <i>initial &amp; repeat TST</i></li> </ul>	<ul style="list-style-type: none"> <li>Contacts ≥ 5 years old who spent ≥ <b>3 nights</b> sleeping in the same room – <i>TST &gt; 8 weeks BIC</i></li> <li>Staff and others with ≥ <b>96 hours</b> cumulative exposure – <i>TST &gt; 8 weeks BIC</i> (for staff, initial TST may also be feasible)</li> <li>Contacts &lt; 5 years old or immunosuppressed contacts with ≥ <b>36 hours</b> cumulative exposure – <i>initial &amp; repeat TST</i></li> <li>If infectious case spent ≥ <b>60 hours</b> in facilities with drop-in services, consider holding site-based screening in addition to the above</li> </ul>	No	Yes		
<b>Correctional Facilities</b>	<ul style="list-style-type: none"> <li>Contacts who spent ≥ <b>5 nights</b> sleeping in the same cell – <i>initial &amp; repeat TST</i></li> <li>Staff and others with ≥ <b>120 hours</b> cumulative exposure – <i>TST &gt; 8 weeks BIC</i></li> </ul>	<ul style="list-style-type: none"> <li>Contacts who spent ≥ <b>3 nights</b> in same cell – <i>initial &amp; repeat TST</i></li> <li>Staff and others with ≥ <b>96 hours</b> cumulative exposure – <i>initial &amp; repeat TST</i></li> </ul>	No	Yes		
<b>Long Term Care, Assisted Living, Hybrid Long Term Care sites and Retirement Facilities, Home Care</b>	<ul style="list-style-type: none"> <li>Residents who spent ≥ <b>5 nights</b> sleeping in the same room or residents with ≥ <b>120 hours</b> cumulative exposure in a medium size space (e.g., classroom or smaller size space) – <i>initial symptom screen and CXR; if symptomatic, collect sputum as well. Consider TST if prophylaxis is an option. Recommend LTCF flag TB exposure on resident chart and conduct enhanced TB symptom surveillance for 2 years.</i></li> <li>Staff with direct patient care and others with ≥ <b>120 hours</b> cumulative exposure in classroom size or smaller airspace – <i>TST &gt; 8 weeks BIC</i></li> </ul>	<ul style="list-style-type: none"> <li>Residents who spent ≥ <b>3 nights</b> sleeping in the same room or residents with ≥ <b>96 hours</b> cumulative exposure in a medium size space (e.g., classroom or smaller size space) or within 8 feet in a larger size room (e.g., large dining hall) – <i>initial symptom screen and CXR; if symptomatic, collect sputum as well. Consider TST if prophylaxis is an option. Recommend LTCF flag TB exposure on resident chart and conduct enhanced TB symptom surveillance for 2 years.</i></li> <li>Staff with direct patient care and others with ≥ <b>96 hours</b> cumulative exposure – <i>TST &gt; 8 weeks BIC</i></li> </ul>	No	Yes		



<b>Hospitals and Clinics</b>	<ul style="list-style-type: none"> <li>Patients with <b>≥48 hours</b> cumulative exposure in the same room, or for larger bay areas the patients in adjacent beds, or participation in patient group activities (e.g. pediatric play room, psychiatric group programs) – <i>TST &gt; 8 weeks BIC, unless &lt;5 years old, initial &amp; repeat TST</i></li> <li><b>All staff</b> involved during AGMPs if not wearing PPE – <i>TST &gt; 8 weeks BIC</i></li> <li><i>All staff working high risk facilities in high risk areas such as emergency and medical wards, the respiratory unit, MICU, pathology, and microbiology/TB bench should receive yearly surveillance. Contact tracing is not routinely needed on these units; yearly surveillance could be adjusted should a significant exposure occur.</i></li> <li>Staff on units not part of the yearly surveillance :             <ul style="list-style-type: none"> <li>At a minimum staff with direct patient care for <b>≥60 hours</b> cumulative exposure</li> <li><i>If time and resources allow, individuals working for more than four 12 hour shifts or six 8 hour shifts after an exposure should be initially considered for follow up investigation and staff with direct patient care for <b>≥24 hours</b> cumulative exposure may be followed. In addition, contacts whose risk score is 1 or 2 could also be managed as high risk.</i></li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Patients with <b>≥ 24 hours</b> cumulative exposure in the same room, or participation in patient group activities (e.g., pediatric play room, psychiatric group programs) – <i>TST &gt; 8 weeks BIC, unless &lt;5 years old, initial &amp; repeat TST</i></li> <li><b>All staff</b> involved during AGMPs if not wearing PPE – <i>TST &gt; 8 weeks BIC</i></li> <li><i>All staff working high risk facilities in high risk areas such as emergency and medical wards, the respiratory unit, MICU, pathology, and microbiology/TB bench should receive yearly surveillance. Contact tracing is not routinely needed on these units; yearly surveillance could be adjusted should a significant exposure occur.</i></li> <li>Staff on units not part of the yearly surveillance :             <ul style="list-style-type: none"> <li>At a minimum staff with direct patient care <b>≥ 36 hours</b> cumulative exposure</li> <li><i>If time and resources allow, all staff working on the unit for more than two 12 hour shifts or three 8 hour shifts should be initially considered for follow up investigation, and staff with direct patient care for <b>≥8 hours</b> cumulative exposure may be followed.</i></li> </ul> </li> </ul>	No	Yes		
<b>Emergency Medical Services</b>	Notify EMS of situation and recommend if any follow-up is needed (use above hospital staff parameters)	Notify EMS of situation and recommend if any follow-up is needed (use above hospital staff parameters)	No	Yes		
<b>Public Travel</b>	<ul style="list-style-type: none"> <li>For air travel, utilize Public Health Agency of Canada guidelines</li> <li>For long distance (i.e.&gt;8 hours) public bus and train travel, consider follow-up only if evidence of transmission among closer contacts</li> <li>No follow-up for local public transit</li> </ul>		No	Yes		
<b>Wound Care</b>	<ul style="list-style-type: none"> <li>Wound specimens smear negative – <i>no screening</i></li> <li>Wound specimens smear <u>and</u> culture positive – staff involved in high pressure irrigation of open TB wounds, orthopedic procedures (i.e., cutting with power tools) or cauterization of TB infected tissue while not wearing an N95 respirator should be screened – <i>TST &gt; 8 weeks BIC</i></li> </ul>		No	Yes		

## 4. Communication

The results from all contact follow up conducted by IP&C and OESH are to be documented on the TB Contact Assessment Form and must be forwarded to Manitoba Health, Seniors, and Active Living (MHSAL) through fax number 204- 948-3775.

**TB Contact Assessment Form**

Administrative Use Only	
Investigation ID#: _____	Exposure Case Event/Location: _____
Contact type: _____	_____
Contact status: _____	Date last exposed: _____ <span style="font-size: small;">(yyyy-mm-dd)</span>

**Reason for Assessment**

Initial contact assessment <input type="checkbox"/>	Assessment $\geq$ 8 weeks after last contact with infectious cases <input type="checkbox"/>	Self-identified contact <input type="checkbox"/>	Screening (client or 3 <sup>rd</sup> party request) <input type="checkbox"/>	Symptoms of TB disease <input type="checkbox"/>
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**Demographics**

Last name	First name	Middle	PHIN#	MHSC#
Address		City/Town		Postal code
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (yyyy/mm/dd)	First Nations <input type="checkbox"/> On reserve <input type="checkbox"/> Off reserve		Treaty #
Home phone number		Work phone number		Cell phone number
Primary Language		Interpreter required? <input type="checkbox"/> No <input type="checkbox"/> Yes _____		
Family Physician		Country/Canadian province of birth		Date entered Canada (yyyy/mm/dd)

**Health Assessment (symptoms experienced in the last year)**

	YES	NO	Date Started (yyyy/mm/dd)	Date Resolved (yyyy/mm/dd)	Comments
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>			
Fever	<input type="checkbox"/>	<input type="checkbox"/>			
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>			
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>			
Pain with breathing	<input type="checkbox"/>	<input type="checkbox"/>			
Cough lasting more than 3 weeks	<input type="checkbox"/>	<input type="checkbox"/>			
Coughing up blood (hemoptysis)	<input type="checkbox"/>	<input type="checkbox"/>			
Have you had contact with a person sick with tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you ever had TB disease?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you had BCG vaccine?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you ever had a Tuberculin Skin Test (TST)?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you been treated for Latent TB Infection (LTBI) in the past?	<input type="checkbox"/>	<input type="checkbox"/>			
History of not completing LTBI therapy/risk of treatment failure?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have allergies?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you had a major viral infection or vaccination in the past 4 weeks (e.g., mumps, measles, rubella, yellow fever, chickenpox)?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>			
Alcohol or other substance use?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have a history of an abnormal chest X-ray?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you recently travelled to a TB endemic area?	<input type="checkbox"/>	<input type="checkbox"/>			



**Do any of the following apply?**

HIV	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
End-stage Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Silicosis					
Transplantation	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer diagnosis	<input type="checkbox"/>	<input type="checkbox"/>			
Tumor necrosis factor alpha (TNF) antagonists	<input type="checkbox"/>	<input type="checkbox"/>			
Prednisone (at least 15 mg/day for >4 weeks)	<input type="checkbox"/>	<input type="checkbox"/>			
Other immune-suppressing condition	<input type="checkbox"/>	<input type="checkbox"/>			

**Exposure Assessment**

TB case ID #	Pan-sensitive <input type="checkbox"/> yes <input type="checkbox"/> no If no specify:	Exposure setting	Exposure date (yyyy/mm/dd)
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Date TST planted (yyyy/mm/dd)	Product	Lot #	Measurement (mm)	Date TST read	TST plant site	Administered by

	YES	NO	Date (yyyy/mm/dd)	Comments
Referred for chest x-ray				
Adverse reaction to TST				
Containers given for sputum collection				
Referred for induced sputum				
Hospitalized due to TB				

**Comments**

Name of individual completing assessment ( <i>please print</i> ):	Date of assessment (yyyy/mm/dd):
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**Communication**

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