

# CLINICAL ASSESSMENT SUSPECTED CASE/CONTACT OF ACTIVE TB CASE

## Section 1: PERSONAL INFORMATION

Sex:  M  F Telephone no.: \_\_\_\_\_ Facebook account or e-mail: \_\_\_\_\_  
 House no.: \_\_\_\_\_ No. of residents: \_\_\_\_\_ No. of bedrooms: \_\_\_\_\_  
 Reason for assessment:  Contact of active case  Search for source case  Professional's request  
 Patient's request  Other: \_\_\_\_\_

**INDEX CASE** Date of birth: yyyy / mm / dd File no.: \_\_\_\_\_ Date of diagnosis: yyyy / mm / dd  
 CXR information:  Cavitary  Non-cavitary BK:  Smear (+)  Smear (-)  Culture (+)  Culture (-)  Unknown

### CONTACT LOCATION AND DETAILS (more than one answer possible)

House of index case  Other house  Workplace  School/Day-care  Social group  Other: \_\_\_\_\_  
 Contact location(s) (specify, e.g., house no., primary school/class, employer): \_\_\_\_\_  
 If *House of index case* or *Other house*, do they sleep in same bedroom? :  N  Y  
 Frequency of contact<sup>1</sup> (per week): \_\_\_\_\_ Duration of contact: \_\_\_\_\_ hrs Date of last contact: yyyy / mm / dd

### HISTORY

BCG vaccination:  N  Y Date(s): yyyy / mm / dd yyyy / mm / dd yyyy / mm / dd  
 Previous active TB:  N  Y Year: \_\_\_\_\_ Treatment completed  N  Y Compliant (%) \_\_\_\_\_  
 Previous LTBI:  N  Y Year: \_\_\_\_\_ Treatment completed **INH or RIF**  N  Y Compliant (%) \_\_\_\_\_  
 Previous TST<sup>2</sup>:  N  Y Date: yyyy / mm / dd Result: mm Date: yyyy / mm / dd Result: mm  
 Date: yyyy / mm / dd Result: mm Date: yyyy / mm / dd Result: mm  
 Previous Quantiferon:  N  Y Date: yyyy / mm / dd Result: \_\_\_\_\_ Date: yyyy / mm / dd Result: \_\_\_\_\_

### CURRENT MEDICAL PROBLEMS

None  Unknown  Other: \_\_\_\_\_  
 Known allergy to TB medication  Head/neck cancer  Diabetes  Organ recipient under treatment  
 Chronic kidney failure  Liver disease  Immunodeficiency immunosuppressive

### MEDICATIONS CURRENTLY TAKEN

None  Other: \_\_\_\_\_  
 Anticonvulsive (specify): \_\_\_\_\_  Hormonal contraceptive (specify): \_\_\_\_\_  
 Corticosteroids (specify): \_\_\_\_\_  Immunosuppressive (specify): \_\_\_\_\_  
 Pregnant?  N  Y  N/A

----- Once information is completed, send Section 1 to DPH<sup>3</sup> -----

## Section 2: RISK FACTORS

Smoking  N  Y Cigarettes per day: \_\_\_\_\_  
 Alcohol use  N  Y Quantity/Frequency: \_\_\_\_\_  
 Cannabis use  N  Y Quantity/Frequency: \_\_\_\_\_ Location: \_\_\_\_\_  
 Presence at gathering places  N  Y (e.g., gambling establishments, cannabis use in groups, etc.)  
 Specify locations if possible (house no., owner name): \_\_\_\_\_

### OTHER RISK FACTORS in past two years:

None  
 Homeless (urban setting)  
 Prior incarceration, specify locations/dates: \_\_\_\_\_  
 Stay in other Nunavik communities/Nunavut/outside region, specify locations/dates: \_\_\_\_\_

<sup>1</sup> Important: indicate frequency (number of visits per week), duration (usual number of hours of such visits) and date of last contact.

<sup>2</sup> Do not include tine test.

<sup>3</sup> DPH addresses: [tuberculose-santepublique.nrbhss@sss.gov.qc.ca](mailto:tuberculose-santepublique.nrbhss@sss.gov.qc.ca) and [vannessa.jean-marie.ciusscn@sss.gov.qc.ca](mailto:vannessa.jean-marie.ciusscn@sss.gov.qc.ca)

**Section 3: INITIAL CLINICAL ASSESSMENT**

**SYMPTOMS**

Unusual cough > 3 weeks  N  Y Start date: yyyy / mm / dd  
 Expectorations  N  Y Duration \_\_\_\_\_ weeks Chest pain  N  Y Duration \_\_\_\_\_ weeks  
 Hemoptysis  N  Y Duration \_\_\_\_\_ weeks Persistent fever  N  Y Duration \_\_\_\_\_ weeks  
 Dyspnea  N  Y Duration \_\_\_\_\_ weeks Night sweats  N  Y Duration \_\_\_\_\_ weeks  
 Unexplained weight loss  N  Y \_\_\_\_\_ kg Fatigue  N  Y Duration \_\_\_\_\_ weeks  
 Other: \_\_\_\_\_

**PHYSICAL EXAMINATION**

Current weight: \_\_\_\_\_ kg Previous weight: \_\_\_\_\_ kg Date: yyyy / mm / dd  
 Pulmonary auscultation:  Normal  Abnormal Specify: \_\_\_\_\_  
 Physical examination (adenopathy, erythema nodosum): Specify: \_\_\_\_\_  
 Date of assessment: yyyy / mm / dd Nurse: \_\_\_\_\_

C-19 or live vaccine (MMR, MMR-chickenpox, zoster, typhoid, Flumist) received in past four weeks<sup>4</sup>:  N  Y → Date: yyyy / mm / dd

**TST #1 required**<sup>5</sup>  N  Y TST performed on: yyyy / mm / dd Time: \_\_\_\_\_ Lot no.: \_\_\_\_\_ Site: \_\_\_\_\_ Nurse: \_\_\_\_\_  
 TST interpreted on: yyyy / mm / dd Time: \_\_\_\_\_ TST result: \_\_\_\_\_ mm Nurse: \_\_\_\_\_

----- At end of initial clinical assessment, send Sections 1-2-3 to DPH<sup>3</sup> -----

**Section 4: FOLLOW-UP CLINICAL ASSESSMENT**<sup>6</sup> Scheduled date: yyyy / mm / dd

**SYMPTOMS**

Unusual cough > 3 weeks  N  Y Start date: yyyy / mm / dd  
 Expectorations  N  Y Duration \_\_\_\_\_ weeks Chest pain  N  Y Duration \_\_\_\_\_ weeks  
 Hemoptysis  N  Y Duration \_\_\_\_\_ weeks Persistent fever  N  Y Duration \_\_\_\_\_ weeks  
 Dyspnea  N  Y Duration \_\_\_\_\_ weeks Night sweats  N  Y Duration \_\_\_\_\_ weeks  
 Unexplained weight loss  N  Y \_\_\_\_\_ kg Fatigue  N  Y Duration \_\_\_\_\_ weeks  
 Other: \_\_\_\_\_

**PHYSICAL EXAMINATION**

Current weight: \_\_\_\_\_ kg  
 Pulmonary auscultation:  Normal  Abnormal Specify: \_\_\_\_\_  
 Physical examination (adenopathy, erythema nodosum): Specify: \_\_\_\_\_  
 Date of assessment: yyyy / mm / dd Nurse: \_\_\_\_\_

C-19 or live vaccine (MMR, MMR-chickenpox, zoster, typhoid, Flumist) received in past four weeks<sup>3</sup>:  N  Y → Date: yyyy / mm / dd

**TST #2 required**  N  Y TST performed on: yyyy / mm / dd Time: \_\_\_\_\_ Lot no.: \_\_\_\_\_ Site: \_\_\_\_\_ Nurse: \_\_\_\_\_  
 TST interpreted on: yyyy / mm / dd Time: \_\_\_\_\_ TST result: \_\_\_\_\_ mm Nurse: \_\_\_\_\_

**Section 5: MEDICAL COURSE OF ACTION**

CXR required<sup>7</sup>  N  Y Date CXR performed: yyyy / mm / dd  
 BK x 3 required  N  Y Dates: GeneXpert yyyy / mm / dd  
 Expecto #1 yyyy / mm / dd Expecto #2 yyyy / mm / dd Expecto #3 yyyy / mm / dd

**Medical follow-up:**

Release  LTBI treatment  
 Clinical-radiological follow-up  Window-period  
 Active TB treatment  prophylaxis

**Clinical impression:**

\_\_\_\_\_  
 \_\_\_\_\_

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ DATE: yyyy / mm / dd

----- At end of investigation, send this form to DPH<sup>3</sup> -----

<sup>4</sup> If yes, administer TST on same day or four weeks after administration of vaccine in question (refer to [PIQ](#)).

<sup>5</sup> For a child < 5 years vaccinated with BCG and identified as contact: if LTBI not confirmed and asymptomatic with normal CXR, **perform TST only at eight weeks after last contact (= at end of window period)**.

<sup>6</sup> To be performed if TST # 2 required or at physician's request. Enter scheduled date of appointment in agenda.

<sup>7</sup> Any 3-projection CXR performed on individual ≥ 5 years old during 3 months preceding diagnosis of presumed source case may be considered as initial CRX and not to be repeated during investigation, on condition this individual **remains asymptomatic and presumed source case has a negative smear.**