National Surveillance Unit, National Epidemiology Branch,
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TUBERCULOSIS CASE INVESTIGATION FORM 1

Form 1 shall be submitted to the Parish Medical Officer of Health, MO(H), within ten (10) weeks of the initial Class 1 Notification to the Health Department and/or Ministry of Health and Wellness of a suspected case of tuberculosis.

SECTION 1 – DEMOGRAPHIC INFORMATION

INITIAL DIAGNOSIS	
◯ Tuberculosis	
Date of Notification (*DD/MM/YYYY*):	Date Investigation Started (*DD/MM/YYYY*):
PATIENT'S DEMOGRAPHICS	
Patient's ID Type: ◯ Driver's License ◯ TRN ◯ Passport ◯ NIN	Patient's ID Number:
First Name:	Middle Name(s):
Last Name:	Pet Name(s):
Patient's Maiden Name (If Applicable):	
Sex Assigned at Birth: ◯ Male ◯ Female	
Name of Facility Where Patient Seen:	Medical Record Number:
Date of Birth (*DD/MM/YYYY*):	Age:
Country of Residence:	Parish (Jamaica):
House Number, Street Name:	
Community:	
Landmark or directions to address:	
Phone Number:	Email Address:
Occupation:	
Name of Workplace/School:	
Address of Workplace/ School:	
Workplace/School Phone Number:	Email Address:

Marital Status:

◯ Married	◯ Visiting union	◯ Widowed	◯ Separated
◯ Common Law	◯ Single	◯ Divorced	◯ Other (specify):

Next of Kin	
First Name:	Last Name:
Pet Name(s):	
Address: Lot/ Street/Community/Parish:	
Name of Workplace/School:	
Address of School/Workplace:	
Phone number:	Email address:

Relationship to the Patient:

◯ Wife	◯ Son	◯ Uncle	◯ Cousin
◯ Husband	◯ Daughter	◯ Aunt	◯ Friend
◯ Mother	◯ Sister	◯ Grandmother	◯ Other
◯ Father	◯ Brother	◯ Grandfather	

CLINICAL PROFILE

Has the patient experienced/Is the patient experiencing any of the following symptoms?

SYMPTOM	DATE OF ONSET (DD/MM/YYYY)	DURATION	SYMPTOM	DATE OF ONSET (DD/MM/YYYY)	DURATION
◯ Cough			◯ Haemoptysis		
◯ Fever			◯ Chest pain		
◯ Night sweats			◯ Other		
◯ Weight loss			Specify Other:		

Medical History

Pre-existing Conditions

◯ Asthma	◯ Diabetes mellitus	◯ HIV/AIDS	◯ Malignancy
◯ Autoimmune	◯ Heart disease	◯ Hypertension	◯ Sickle cell disease
◯ Chronic Obstructive Pulmonary Disease (COPD)	◯ Kidney disease	◯ Liver dysfunction	◯ Other Specify Other:

Pregnancy

Is Patient Pregnant: ◯ Yes ◯ No ◯ Unsure ◯ NA	Date of LMP (DD/MM/YYYY):
Gestational Age:	Trimester: ◯ First ◯ Second ◯ Third

HIV Testing

HIV Screening Test Type:	HIV Confirmatory Test Type:
Date of HIV Screening Test (DD/MM/YYYY):	Date of HIV Confirmatory Test (DD/MM/YYYY):
HIV Screening Test Results: ◯ Positive ◯ Negative ◯ Indeterminate	HIV Confirmatory Test Results: ◯ Positive ◯ Negative ◯ Indeterminate

Viral load and CD4 count for persons living with HIV

Viral Load result: copies per millilitre	Date viral load sample taken (DD/MM/YYYY):
CD4 Count result: cells per microlitre	Date CD4 Count sample taken (DD/MM/YYYY):

ANTIRETROVIRAL (ARV) MEDICATION HISTORY?

Past or Current Medication	Dosage	Frequency	Actual Duration Received (weeks)	Comments
◯ Tenofovir				
◯ Lamivudine				
◯ Emtricitabine				
◯ Dolutegravir				
◯ Abacavir				
◯ Zidovudine				
◯ Nevirapine				
◯ Lopinavir/ritonavir				
◯ Other (specify):				

OTHER MEDICATION HISTORY:				
◯Trimethoprim-Sulfamethoxazole/ Co-trimoxazole (Bactrim)				
◯ Other (specify):				
◯ Other (specify):				
◯ Other (specify):				

VACCINATION STATUS

Type of Vaccine	Source of vaccination Information (Vaccination card, Health service record, Verbal)	BCG Scar seen
BCG		◯ Yes ◯ No

Substance Use	Frequency	Duration
◯ Tobacco		
◯ Ganja/marijuana/cannabis		
◯ Alcohol		
◯ Other substance (please specify): ----------		

TRAVEL PROFILE

Are there other cases present in the case's community of residence? ◯ Yes ◯ No

Travelled in the last 6 weeks: ◯ Yes ◯ No ◯ Unknown

If travelled: ◯ Domestic Travel ◯ International Travel ◯ Domestic and International Travel

If international travel, fill out the table below:

Country Visited	City Visited	Accommodation	Date Arrived in Country *(DD/MM/YYYY)*	Date Departed Country *(DD/MM/YYYY)*

Date returned to Jamaica *(DD/MM/YYYY)*:

If local travel, fill out the table below:

Address	Parish	Date Arrived *(DD/MM/YYYY)*	Date Departed *(DD/MM/YYYY)*

Date returned to home address *(DD/MM/YYYY)*:

Has the patient been in contact with someone who travelled in the past 6 weeks? ◯ Yes ◯ No ◯ Unknown

SECTION 2 – DIAGNOSTIC SCREENING

MANTOUX TEST			
Mantoux test done: ◯ Yes ◯ No	Mantoux test date (DD/MM/YYYY):		
Mantoux test reading ---------- mm	Mantoux test interpretation: ◯ Positive ◯ Negative		
Reference: Immunocompetent 10 mm or more (positive); Immunocompromised 5 mm or more (positive)			
CHEST X-RAY			
Chest X-ray done: ◯ Yes ◯ No	Chest X-ray date (DD/MM/YYYY):		
Chest X-ray description/ findings/result:			
Chest X-ray interpretation: ◯ Positive ◯ Negative ◯ Indeterminate			
OTHER INVESTIGATIONS			
Other Investigation Done: ◯ Yes ◯ No	Type of Investigation:		
Date Investigation Done (DD/MM/YYYY):			
Result of Investigation:			
LABORATORY TESTING FOR MYCOBACTERIUM TUBERCULOSIS			
Sputum specimen collected	◯ Yes ◯ No		
	Sputum Sample 1	Sputum Sample 2	Sputum Sample 3
Sputum specimen collection date(s), (DD/MM/YYYY):			
Sputum microscopy for acid fast bacilli (AFB) done	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Sputum microscopy result (e.g., AFB 1+)			
Sputum microscopy interpretation	◯ Positive ◯ Negative ◯ Indeterminate ◯ Sample rejected	◯ Positive ◯ Negative ◯ Indeterminate ◯ Sample rejected	◯ Positive ◯ Negative ◯ Indeterminate ◯ Sample rejected
	Sputum Culture 1	Sputum Culture 2	Sputum Culture 3
Sputum culture for Mycobacterium tuberculosis done	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Sputum culture result			
Sputum culture interpretation	◯ Positive ◯ Negative ◯ Indeterminate ◯ Sample rejected	◯ Positive ◯ Negative ◯ Indeterminate ◯ Sample rejected	◯ Positive ◯ Negative ◯ Indeterminate ◯ Sample rejected

Rifampicin resistance detected on Mycobacterium tuberculosis culture	◯ Resistant ◯ Not resistant ◯ Indeterminate		
Other drug resistance detected on Mycobacterium tuberculosis culture	◯ Yes ◯ No ◯ Not Done		
If yes, specify other drug resistance detected:			
	Sputum Sample 1	Sputum Sample 2	Sputum Sample 3
Gene Xpert or polymerase chain reaction (PCR) done	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Gene Xpert or polymerase chain reaction (PCR) results interpretation	◯ Positive ◯ Negative ◯ Indeterminate ◯ Sample rejected	◯ Positive ◯ Negative ◯ Indeterminate ◯ Sample rejected	◯ Positive ◯ Negative ◯ Indeterminate ◯ Sample rejected
Rifampicin resistance detected on Gene Xpert or polymerase chain reaction (PCR)	◯ Resistant ◯ Not resistant ◯ Indeterminate	◯ Resistant ◯ Not resistant ◯ Indeterminate	◯ Resistant ◯ Not resistant ◯ Indeterminate

SECTION 3 – ANTI-TUBERCULOSIS TREATMENT INITIATION: INTENSIVE PHASE

Date started **Intensive Phase of anti-TB treatment** DD/MM/YYYY):	Date completed **Intensive Phase of anti-TB treatment** (DD/MM/YYYY):
Name of hospital:	
Date of admission (DD/MM/YYYY):	Date of discharge (DD/MM/YYYY):
Directly Observed Therapy (DOT): ◯ Yes ◯ No	

ANTI-TUBERCULOSIS TREATMENT

Past or Current Medication	Dosage	Actual Duration Received (weeks)	Comments
◯ Isoniazid			
◯ Rifampicin			
◯ Pyrazinamide			
◯ Ethambutol			
◯ Streptomycin			
◯ Other			
◯ Other			

SECTION 4 – SOCIAL ASSESSMENT

LIVING ARRANGEMENT		
◯ Lives alone	◯ Lives with partner	◯ Lives with family
◯ Lives with friends	◯ Other (Specify Other):	
Number of household members: ------		
DWELLING TYPE		
◯ Separate House-Detached	◯ Apartment Building	◯ Townhouse
◯ Other Attached	◯ Part of Commercial Building	◯ Improvised Housing Unit
◯ Homeless	◯ Non-response	◯ Other (Specify):
Number of rooms:	Number of bedrooms:	Number of persons per bedroom:
Water Supply: ◯ Good	◯ Fair	◯ Poor
Ventilation: ◯ Good	◯ Fair	◯ Poor
Cleanliness: ◯ Good	◯ Fair	◯ Poor
FOOD AND NUTRITION SUMMARY		
Milk supply: ◯ Pasteurised	◯ Unpasteurised	
WORKPLACE ARRANGEMENT		
Risk Level (Crowding): ◯ Low	◯ Medium	◯ High
Notes (e.g., about contacts; industry):		

SECTION 5 – CONTACT TRACING

First Name	Last Name	D.O. B (DD/MM/YYYY)	Sex	Relation	Address	Phone	Symptoms	Previous BCG	Mantoux		Further Evaluation	Evaluation Date (D/M/YYYY)	Findings	Classification	Comments
									Date (D/M/Y)	Result (mm)					
			◯ M ◯ F				◯ Cough ◯ Fever ◯ Night Sweats ◯ Weight Loss ◯ Asymptomatic	◯ Yes ◯ No			◯ Chest X-ray ◯ Sputum ◯ Other			◯ Suspected ◯ Previously Treated ◯ Latent TB ◯ Discarded	
			◯ M ◯ F				◯ Cough ◯ Fever ◯ Night Sweats ◯ Weight Loss ◯ Asymptomatic	◯ Yes ◯ No			◯ Chest X-ray ◯ Sputum ◯ Other			◯ Suspected ◯ Previously Treated ◯ Latent TB ◯ Discarded	
			◯ M ◯ F				◯ Cough ◯ Fever ◯ Night Sweats ◯ Weight Loss ◯ Asymptomatic	◯ Yes ◯ No			◯ Chest X-ray ◯ Sputum ◯ Other			◯ Suspected ◯ Previously Treated ◯ Latent TB ◯ Discarded	
			◯ M ◯ F				◯ Cough ◯ Fever ◯ Night Sweats ◯ Weight Loss ◯ Asymptomatic	◯ Yes ◯ No			◯ Chest X-ray ◯ Sputum ◯ Other			◯ Suspected ◯ Previously Treated ◯ Latent TB ◯ Discarded	
			◯ M ◯ F				◯ Cough ◯ Fever ◯ Night Sweats ◯ Weight Loss ◯ Asymptomatic	◯ Yes ◯ No			◯ Chest X-ray ◯ Sputum ◯ Other			◯ Suspected ◯ Previously Treated ◯ Latent TB ◯ Discarded	

Patient's Name:_____ Medical Record Number: ----------

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SECTION 6 (TB FORM 1) - CLASSIFICATION

Classification of Case			
◯ Confirmed		◯ Pending	◯ Inconclusive
◯ Discarded			
Confirmation Category			
◯ Bacteriologically confirmed		◯ Clinically diagnosed	
Anatomical site			
◯ Pulmonary		◯ Extra-pulmonary	
Drug resistance			
◯ None	◯ Rifampicin resistant	◯ Multi-drug resistant	◯ Extremely drug-resistant
Previous TB Treatment			
Previously treated for tuberculosis? ◯ Yes ◯ No		Relapse case? ◯ Yes ◯ No	
Treatment after lost to follow-up? ◯ Yes ◯ No		Treatment after failure? ◯ Yes ◯ No	
Treatment status for current diagnosis			
◯ Completed		◯ Not completed	
Status for current diagnosis			
◯ Admitted for Intensive Phase	◯ Discharged from Intensive Phase		◯ Started Continuation Phase
◯ Lost to follow-up	◯ Died		
Cause of Death			
(i)	(ii)		(iii)
Immediate	Intermediate		Underlying
Date of death (DD/MM/YYYY):			
REVIEW AND SIGNATURE			
Name of Investigator:		---------- Signature of Investigator	Date Signed by Investigator (DD/MM/YYYY)
Comments:			
Name of Parish Medical Officer (Health):		---------- Signature of MO(H)	Date signed by MO(H) (DD/MM/YYYY)

Patient's Name:_____ Medical Record Number: ----------