Questions	Assessment	Notes
INITIAL EVALUATION		
a) Initial pre-treatment bacterial burden	[low, moderate, high]	
B1) Treatment Regimen		
b2)DST and Effectiveness of therapy	[Low/No Concern for DR-TB, High concern, Uncertain or confirmed DR-TB]	
c) Initial community risk assessment	[Low/Moderate/High/Variable]	
d)Assessment of current infectiousness (NTCA Table 3):	[Non-infectious, Lowest, Low, Moderate, Highest]	
f)Concerns about restrictions:	[low, moderate, high]	
g) Initial Restriction determination (Table 2):	None/Low/Moderate/Extensive	
h) Restriction start date:		
WEEKLY REEVALUATION		
1.How long has PWTB been under total RIR?	Community: Hospital: Total:	
2.How long has PWTB been on therapy?		
2a.Is there evidence that treatment regimen is effective?	a)GXP or molecular testing: Rifampin-Sensitive/Resistant b)Phenotypic DST: Susceptible/Resistant/Pending c)Smear-grade declining d)Clinical symptom improvement	
3.What is current assessment of PWTB Infectiousness	Non-infectious, Lowest, Low, Moderate, Highest]	
4. What is current assessment of Community Transmission Risk	[Low/Moderate/High/Variable]	
5.Assess potential harms to PWTB associated with TB diagnosis, treatment, and isolation:	Financial:Y/N, Stigma: Y/N, Housing: Y/N, Food: Y/N, Mental Health: Y/N	
Determine if RIR should be continued	[Continue, Discontinue, Modify]	
RESTRICTION SUMMARY		
a)Any Restriction start date		
b))Hospital restriction start date		
c)Hospital restriction end date		
d)Community restirction start date		
e)Community restriction end date		
f)All restriction end date:		
g)Total duration (days) of restriction:		

PLEASE SEE INSTRUCTIONS FOR DETAILS ON ANSWERING SPECIFIC QUESTIONS IN THE ISOLATION CHECKLIST

INSTRUCTIONS:

INITIAL: New Diagnosis (Reference: See Table 4 Implementation Aid for Newly Diagnosed persons with TB)

1.ASSESS INFECTIOUSNESS AND TRANSMISSION RISK

a) Initial pre-treatment bacterial burden: [low, moderate, high]

Instructions: Review Chest Imaging (cavitary or not), Review Initial Smear (Smear-positive or negative). Low=Smear-negative and no cavity; High=Smear-positive and Cavitary

Additional Considerations: Individuals without prior imaging or bacteriologic evaluation of TB involvement in the respiratory tract should have assessment that includes a chest radiograph and expectorated sputum evaluation using smear microscopy, NAAT, and culture, when possible. Individuals with pretreatment cavitation or sputum smear or NAAT positivity may have a higher initial bacterial burden and may be relatively more infectious than individuals with sputum smear and/or NAAT-negative samples (see Rec 3.1). Children under 10 y, particularly those with limited bronchial, laryngeal, or pulmonary involvement and minimal cough, are not generally regarded as infectious.

b) Review Initial DST and the Treatment Regimen: [Low/No Concern for DR-TB, High concern, Uncertain or confirmed DR-TB]

Instructions: Is there any concern for drug resistance based on initial NAAT testing, epidemiologic risks, or other considerations? If yes or unsure, consult with expert clinician on initiation of regimen for drug-resistant TB.

Additional Considerations: Molecular DST should be used, when possible, to rapidly assess at least rifamycin susceptibility (eg, GeneXpert MTB/RIF [Cepheid Inc, Sunnyvale, California]). If rapid molecular or phenotypic DST is unavailable, initial drug selection and determination of ATT effectiveness is based on the epidemiologic likelihood of drug resistance and may consider clinical response to treatment. Individuals with suspected or identified drug resistance should have additional evaluation (eg, CDC Molecular Detection of Drug Resistance testing; phenotypic DST to first- and second-line drugs) to confirm the effectiveness of a chosen ATT regimen.

c) Initial community risk assessment (Assess each of the following: 1.Housing, 2. Employment/school setting, 3. Vulnerable populations 4.Other High-risk environments):[Low/Moderate/High/Variable]

Instructions: Consider risk of transmission to the community (answering yes to 1 or more suggests relatively higher risks of community transmission and may required individualized restrictions

Additional Considerations:

1.Assess housing—Is there shared ventilation with individuals who have not been previously exposed? If so, assess if transmission risks can be mitigated (ie, wear a surgical mask or minimize time spent in shared environment with others), or consider alternative housing options.

2.Assess employment, school setting, social activities, and other settings where PWTB will spend time—Is there likely to be prolonged (eg, multiple hours) or repeated contact in close proximity (eg, same room) with others, particularly previously unexposed?

3.Is there likely to be contact with vulnerable populations (children, immunosuppressed individuals, such as in healthcare settings)?

4.Are there higher-risk environments (consider ventilation, space, density of occupants) where the PWTB is anticipated to spend time?

d)Assessment of current infectiousness (NTCA Table 3): [Non-infectious, Lowest, Low, Moderate, Highest]

Instructions: Individuals without pulmonary TB are considered non-infectious

--Individuals with low pre-treatment bacterial burden [1a], who have taken >5 days of effective treatment are considered to be non-infectious or lowest likelihood of infectiousness

--Individuals with high pre-treatment bacterial burden[1a] who have taken > 5 days of effective treatment are considered to have low likelihood of infectiousness (longer durations of treatment increase certainty of transitioning to lowest likelihood of infectiousness)

--Individuals who have not taken at least 5 days of effective treatment are expected to have moderate to highest likelihood of infectiousness

2.DETERMINE Respiratory Isolation and Restrictions (RIR)

a)Concerns about restrictions: [low, moderate, high]

Instructions: Document any PWTB concerns about respiratory restrictions (Financial, Housing, Employment, Cost, Mental Health Stigma)

b) Initial Restriction determination (Table 2): None/Low/Moderate/Extensive

*Instructions: Determine whether community-based Respiratory Isolation and Restrictions (RIR) is indicated. Community based RIR is indicated for most PWTB with pulmonary or respiratory involvement who have not completed **at least** 5 days of effective therapy. The decision to recommend RIR should consider the potential benefits and harms to the patient and to the community. Prior to implementation, community-based RIR should be discussed with the patient to identify potential harms that can be modified.The least-restrictive measures to achieve goals of reducing community TB transmission should be used based on the characteristics of the setting and infectiousness of the PWTB (see Rec 5.1). Home or community-based RIR is preferred, when possible, over hospital-based RIR. In most instances, outdoor activities that are low risk for TB transmission should be allowed. More extensive restrictions may be warranted prior to treatment initiation, with moderate restrictions once on effective ATT. The intensity and duration of RIR should be determined based on specific individual considerations and clinical and community context. Appropriate supportive*

services should be used to minimize the harm of RIR, such as provision of nutritious, culturally appropriate food, phone or video contact with friends, and remote access to school and employment where possible (see NTCA Rec 5.3).

c) Restriction start date:

WEEKLY RE-EVALUATION (Reference—See Table 5) for individuals for whom community based RIR has been implemented

1.How long has PWTB been under community-based RIR?

Instructions: Decisions should be reassessed at least weekly, as well as an assessment of infectiousness, and changing circumstances related to patient and community benefits and harms

2.How long has PWTB been on effective therapy?

Instructions: *Effective ATT is defined as a multidrug regimen to which the organism is susceptible or anticipated to be susceptible. Duration of effective therapy is based on assessment of likelihood of adherence and tolerability. DOT or vDOT may increase certainty of adherence through verification of ingestion.*

3.Assess PWTB Infectiousness Non-infectious, Lowest, Low, Moderate, Highest]

Instructions:

--Individuals with low pre-treatment bacterial burden [1a], who have taken >5 days of effective treatment are considered to be non-infectious or lowest likelihood of infectiousness

--Individuals with high pre-treatment bacterial burden[1a] who have taken > 5 days of effective treatment are considered to have low likelihood of infectiousness (longer durations of treatment increase certainty of transitioning to lowest likelihood of infectiousness)

--Individuals who have not taken at least 5 days of effective treatment are expected to have moderate to highest likelihood of infectiousness

Additional considerations: *If full DST is unavailable, decisions may be made based on available information (eg, rifamycin susceptibility) and clinical assessment of probability of drug resistance. While ATT rapidly reduces a PWTB's infectiousness there may be individual variability. Clinicians may use*

individualized judgment in assessing infectiousness based on pre-ATT bacterial burden (ie, initial sputum AFB smear status and cavitation), clinical response to ATT, drug susceptibility, adherence, and duration of ATT. Available data do not support repeated sputum smear microscopy and NAAT testing solely to assess ongoing infectiousness during ATT. Some clinicians may consider repeat sputum bacteriologic labs to monitor effectiveness of ATT response. However, changes to sputum smear, culture, and NAAT test results on ATT may not correlate with a PWTB's infectious potential.

4. Assess Community Risk of Transmission

Instructions Is there high risk of community TB transmission? (see 1c above)

5.**Assess potential harms to PWTB associated with TB diagnosis, treatment, and isolation:**

Instructions: There is no single validated tool to evaluate multiple dimensions of harm. NTCA Supplemental Appendix 1 includes a set of signalling questions that may be used to screen individuals for potential harms.

--Financial: Yes or No (*Consider inquiring about employment, available emergency funds)*

--Stigma: (*Consider administering TB stigma scale, asking about social network)*

--Housing: (Consider inquiring about rent/mortgage, housing stability, or any other housing concerns)

--Food: (Does patient have concerns for food security)

–-Mental Health: (Several tools are available such as PHQ-9 with screening questions that can be utilized)

6) **Determine if RIR should be continued:[**Continue, Discontinue, Modify]

Instructions: RIR should be discontinued for most PWTB who are assessed to have low infectious potential or situations with low community risk of transmission. RIR may be extended (i.e., until lowest infectious potential) based on comprehensive assessment of the PWTB's infectiousness (see above), community risks and consequences of TB transmission, and individual harms. Some considerations that may warrant extended RIR despite a PWTB's low infectious potential include: 1)Anticipated exposures to vulnerable populations including children <5 years (eg, daycares, schools), and immunosuppressed individuals (eg, healthcare settings); 2)Anticipated return to congregate living facilities (eg, homeless shelters) or densely populated environments with poor ventilation;3)Known or suspected TB drug resistance where the consequences of transmission should be weighed with the harms of prolonged RIR.

Additional considerations: Decisions to extend RIR should balance individual harms of prolonged restrictions, with anticipated community benefits. Instances where duration has extended beyond 14 days warrant additional review and expert consultation (see NTCA Rec 1).

RESTRICTION SUMMARY: Enter the start and end dates for each of the following.

a)Any Restriction start date

b)Hospital restriction start date

c)Hospital restriction end date

d)Community restirction start date

e)Community restriction end date

f)All restriction end date:

g)Total duration (days) of restriction:

RESOURCES

Table 1. Recommendations for Community-Based Respiratory Isolation and Restriction for Persons With Tuberculosis

Recommendation 1: Goals of RIR	1.1. The decision to recommend TB RIR should consider the potential benefits and harm for both the community and the PWTB.
Recommendation 2: Defining RIR (Table 2)	2.1. RIR in community settings should be conceptualized as a spectrum of tailored restrictions that are individualized for specific circumstances (Table 2).
Recommendation 3: Determining infectiousness and transmission risk (Figure 1)	3.1. Prior to effective[a] ATT initiation, PWTB with higher respiratory bacterial burden (ie, sputum smear and/or NAAT positivity, cavitation on chest imaging) may be considered as relatively more infectious than those with lower bacterial burden, with individual variability. 3.2. PWTB on less than 5 days of effective ATT should be considered relatively more infectious than those on longer durations of effective[a] therapy. 3.3. PWTB on effective[a] ATT for at least 5 days should be considered noninfectious or as having a low likelihood of infectiousness, regardless of sputum bacteriologic status during ongoing ATT (ie, smear microscopy or culture status), with certain exceptions.[b] 3.4. Overall risk of transmission to others should consider both a PWTB's infectiousness, as well as other factors including the environment of potential exposures, durations of exposure, and biological susceptibility of contacts.
Recommendation 4: Determining RIR (Table 3)	4.1. RIR is not recommended for persons with noninfectious forms of TB (ie, localized extrapulmonary TB without pulmonary involvement, as confirmed by sputum bacteriologic studies and/or chest imaging). 4.2. People with pulmonary TB on effective[a] ATT and a low likelihood of infectiousness should not have restrictions in most circumstances (ie, RIR should be removed, if present),[b] with individual exceptions for situations involving higher-risk community settings and populations (eg, children <5, immunosuppressed individuals). 4.3. Community-based RIR may be considered for PWTB who have higher infectious potential in which there is judged to be higher risk of transmission to the community.
Recommendation 5: Determining level of RIR (Table 3)	5.1. When community-based RIR is indicated for a PWTB, a moderate or midlevel range of RIR (Table 2) should be considered appropriate in most circumstances, with individual exceptions. 5.2. Specific RIR levels (eg, low, moderate, or extensive; Table 2) and duration for PWTB should be reassessed routinely (at least weekly) and may be modified based on individual considerations or changing circumstances. 5.3. When RIR is implemented, support should be provided to patients to mitigate anticipated and experienced harms.

Abbreviations: ATT, anti-tuberculosis therapy; NAAT, nucleic acid amplification test; PWTB, person or persons with tuberculosis; RIR, respiratory isolation and restriction; TB, tuberculosis.

[a]Effective ATT is defined as a recommended multidrug regimen to which the organism is susceptible or anticipated to be susceptible.

[b]No single test or ATT duration universally predicts noninfectiousness. While there is individual variability in infectiousness, available evidence indicates most PWTB are unlikely to transmit to others after the first few days (24–72 h) of ATT initiation. Recognizing pragmatic considerations for time needed to assess ATT adherence and tolerance, and conduct clinical and public health evaluation, community-based RIR can be discontinued in most circumstances after 5 days of ATT, with certain exceptions. Additional factors that may be considered when assessing ongoing infectiousness include the initial bacterial load (eg, high pre-ATT bacterial burden), adequacy of ATT regimens (bactericidal and sterilizing potential; drug susceptibility), and/or adherence and clinical response to ATT; sputum bacteriologic status during ATT is not expected to provide information that reliably correlates with infectiousness. Individualized extensions may be warranted in settings and situations with higher risk or consequence of transmission, including exposures to children <5 years and immunosuppressed or other vulnerable populations. The optimal duration of RIR in such situations is uncertain and should balance community risks and benefits. While PWTB on longer durations of ATT are expected to be less infectious than those on shorter durations, longer durations of RIR are anticipated to result in increased patient harms. Expert consultation or additional review should be sought when RIR has extended beyond 14 days.

Table 2. Spectrum of Respiratory Isolation and Restriction for Persons With Tuberculosis in a Community-Based Setting

Extensive restriction	1. Individuals should strictly limit their movement to an agreed-upon location, such as a home or other residence. 2. Any exceptions to extensive RIR should be discussed and agreed upon with the local health department officials. 3. When an individual leaves the primary site of RIR (such as for a healthcare visit), additional measures to reduce TB transmission risk may be warranted, including but not limited to, personal protective equipment (eg, N95 masks) for close contacts, face masks (ie, surgical masks, KN95, N95) for the PWTB, and efforts for improved ventilation (eg, open windows during transportation in cars, negative-pressure rooms or HEPA filters). 4. Visitors not living in the residence should be avoided unless approved by the local health department and should wear personal protective equipment (eg, N95).
Midlevel/moderate restrictions	1. Individual spends majority of time at an agreed-upon location, such as a home or residence. 2. Individual may leave the location for most outdoor activities and some indoor activities deemed essential, as determined through discussion with public health department officials: a. Individual may engage in most activities in outdoor or well-ventilated environments[a]; b. Strategies to minimize aerosols including wearing a mask (ie, surgical mask, KN95, N95) should be utilized for indoor activities, particularly if there is contact with previously unexposed individuals; c. Indoor activities should avoid prolonged (eg, multiple hours), or repeated close contact with others, particularly individuals not previously exposed or vulnerable populations (eg, children, immunosuppressed individuals)[a]; d. Indoor activities in settings of poor ventilation or dense populations should be avoided[a]; e. In settings at higher risk of transmission (eg, healthcare visit), or potential risk of transmission to vulnerable populations (eg, immunosuppressed, children), additional measures to reduce transmission risk may be warranted, including but not limited to, personal protective equipment (eg, N95 masks) for close contacts, face masks (ie, surgical masks) for the PWTB, and efforts for improved ventilation (eg, negative-pressure rooms or HEPA filtration systems). 3. Visitors should be avoided unless approved by the local health department and should wear personal protective equipment (eg, N95).
No restriction	1. Individuals have no restrictions and may engage in daily activities as usual, irrespective of setting or potential contacts.

Levels should not be considered absolute but represent a framework for individual judgments. The duration of restrictions should consider both the individual's infectiousness (Figure 1, chart A), as well as the potential risks and consequences of transmission to others (Figure 1, chart B) and are summarized in Table 3.

Abbreviations: HEPA, high-efficiency particulate air; PWTB, person or persons with tuberculosis; RIR, respiratory isolation and restriction; TB, tuberculosis.

[a]Studies suggest that transmission risk is lower in outdoor settings and locations with natural ventilation and/or UV light, compared with shared indoor airspace and closed-ventilation systems. Other factors that influence the likelihood of transmission from a PWTB to an exposed contact include duration, frequency, and proximity of exposures. There is no minimum duration, frequency, or proximity of exposure that defines likelihood of transmission. While short durations or infrequent exposure could lead to *Mycobacterium tuberculosis* infection, many contacts are not infected after longer durations (weeks to months) of intensive exposure. Overall, the probability of transmission is expected to increase with more frequent (ie, daily) contact for longer durations (eg, >8 h), in indoor settings at close proximity.

Table 3. Integrated Schematic and Decision Aid to Support Community-Based Respiratory Isolation and Restriction Recommendations for Individuals With Pulmonary Tuberculosis

Recommendation 3: Determining Infectiousness			Recommendation 4: Determining RIR	Recommendation 5: Level of RIR	Notes
ATT status	Pretreatment respiratory bacterial burden[a]	Assessment of individual infectiousness[a,b]	Is RIR indicated?[c]	What level of RIR to choose? (Rec 2; Table 2)	Specific recommendations should balance community and patient risks and benefits (Rec 1)
Pretreatment	High	Highest (Rec 3.1)	Yes (Rec 4.3)	Extensive	Support should be provided to mitigate harm to PWTB (Rec 5.3)
	Low	Moderate (Rec 3.1)	Yes (Rec 4.3)	Extensive or moderate (Rec 5.1)	
Treatment ≤5 d	High	Moderate (Rec 3.2)	Yes (Rec 4.3)	Moderate (Rec 5.1)	
	Low	Moderate/low (Rec 3.2)	Yes (Rec 4.3)	Moderate (Rec 5.1)	
Treatment >5 d	High	Low (Rec 3.3)[b]	Not indicated in most situations (Rec 4.2)[d]	None	Individual exceptions to continue RIR may be considered (Rec 5.2)[d]
	Low	Lowest (Rec 3.3)		None	

Abbreviations: ATT, anti-tuberculosis therapy; NAAT, nucleic acid amplification test; PWTB, person or persons with tuberculosis; Rec, Recommendation (from Table 1); RIR, respiratory isolation and restriction; TB, tuberculosis.

[a]Prior to treatment, assessment of respiratory bacterial burden may include sputum smear microscopy testing (smear positivity and grade), NAAT (lower cycle thresholds may indicate higher bacterial burden), and/or cavitation. Before ATT initiation, higher bacterial burden (and strength of aerosolization) may be associated with greater infectious potential (see Figure 1, chart A, *y*-axis).

[b]There is individual variability in the rate of decline of infectiousness following ATT initiation, but available evidence suggests rapid decline in infectiousness after treatment initiation. Most individuals should be considered to have a low likelihood of infectiousness after 5 days of effective ATT, defined as a multidrug treatment regimen to which the organism is susceptible or anticipated to be susceptible (see Figure 1, chart A, *x*-axis). Factors that may be associated with a longer duration of infectiousness may include high pretreatment respiratory bacterial burden (eg, cavitation, based on initial sputum smear and/or NAAT status), bactericidal and sterilizing activity of the treatment regimen, and adherence and tolerance of treatment. Final decisions on RIR should also include an assessment of net transmission risk to others in the community (see Figure 1, chart B).

[c]The decision to recommend TB RIR should consider the potential benefits and harm for both the community and the PWTB (Rec 1.1).

[d]Additional restrictions or longer duration may be considered in some scenarios of known or suspected drug-resistant TB, higher-risk community settings (eg, longer duration, frequency, and increased proximity of previously unexposed contacts in indoor settings with poor ventilation), potential exposure to vulnerable contacts (eg, children <5, immunosuppressed individuals), slow or inadequate clinical response to ATT, or inadequate adherence to daily ATT. Specific recommendations should balance community well-being and patient impact. Additional review or expert consultation is warranted when RIR is extended beyond 14 days.

- Community based respiratory isolation and restrictions (RIR) is a public health intervention to reduce transmission of TB in community settings, but may limit individual liberties, and should be tailored to balance benefits and harms.

- TB transmission is a multi-factorial event based on individual infectiousness, aerosolization of infectious *M. tuberculosis*, and the environment, duration, and frequency of exposures to an uninfected contact. There is no available laboratory test, or anti-tuberculosis therapy (ATT) duration that reliably predicts individual infectiousness, particularly after ATT initiation.
    - The highest risk of transmission from a person with tuberculosis (PWTB) to others is prior to ATT initiation, particularly in poorly ventilated settings where there is prolonged or repeated contact with others at close proximity.
    - Before effective therapy, individuals with higher pre- ATT pulmonary bacterial burden may be more infectious than individuals with lower bacterial burden.

- Community based RIR is recommended for PWTB with higher infectious potential (i.e., not yet on at least five days of ATT) and risk of transmission in the community.

- When community based RIR is recommended, a *moderate* level of restrictions that is tailored to reduce risk of community transmission while mitigating negative consequences to PWTB from RIR is appropriate in most instances.
    - Outdoor activities (i.e., well ventilated areas) with limited frequency and contact with others have low overall risk of TB transmission, and should be allowed in most instances.
    - More extensive restrictions may be appropriate prior to ATT initiation.

- Most PWTB on effective therapy for at least five days have low infectious potential or are non-infectious, irrespective of sputum-based laboratory tests that are collected while on ATT.
    - Effective therapy is defined as a multi-drug ATT regimen to which the organism is susceptible or anticipated to be susceptible. If full DST is unavailable, decisions may be made based on available information (e.g., rifamycin susceptibility), and clinical assessment of probability of drug-resistance.
    - Community-based RIR should be discontinued after five days of effective ATT in most instances.
        - RIR recommendations (duration and level) may be tailored for PWTB on effective ATT on an individual basis to reduce risk of transmission to vulnerable populations (such as children less than age 5, immunosuppressed individuals), to prevent transmission of drug-resistant TB or conduct additional evaluation for individuals with known or suspected drug-resistant TB, or minimize transmission potential in other high risk community settings.
    - Microbiological assessment of sputum (i.e., smear-microscopy, NAAT, culture) *during ATT* is often a component of clinical care assessments for PWTB (e.g., 2-month culture conversion, end of ATT assessment of microbiological cure), but is not expected to provide information that reliably correlates with infectiousness for purposes of public health decisions related to community based RIR.
    - Additional review or expert consultation should be considered when community based RIR duration extends beyond fourteen days.

Figure 2. Summary of key principles when considering community-based respiratory isolation and restriction for persons with pulmonary tuberculosis. Abbreviations: ATT, anti-tuberculosis therapy; DST, drug-susceptibility testing; NAAT, nucleic acid amplification test; PWTB, person or persons with tuberculosis; RIR, respiratory isolation and restriction; TB, tuberculosis.

Examples of probing questions to assess impact and concerns of community-based RIR for PWTB

General	• What are your feelings and thoughts about the proposed restrictions? • Do you anticipate any challenges to following the proposed restrictions?
Stigma	• Do you feel that people may not consider you or listen to you because of TB? [1] • Are you afraid to tell your family that you have TB? [2] • Are you concerned that TB will affect your relationships to others in your family or community?
Housing	• Are you experiencing homelessness? [3] • Do you feel unsafe inside your home? [3] • Do you worry about being forced to move? [3]
Food	• In the past year were you ever hungry but did not eat because there wasn't enough money for food? [4, 5] • In the past year could you often, sometimes, or never afford to eat balanced meals? [4, 5] • Are you concerned about access to food as a result of your TB diagnosis or treatment plan?
Job Security	• Do you think you might lose your job in the near future? [6] • Are you able to work remotely? • How do you anticipate respiratory isolation and restrictions will impact your current or future employment?

Financial Security	• In the past year have you have trouble paying for: [7]
	  ○ Rent or mortgage
	  ○ Medical care
	  ○ Other bills
	• Have you borrowed money in the past year? [7]
	• Do you have concerns about money during respiratory isolation and restrictions?

Mental Health	<u>(Additional existing tools may include but are not limited to the PHQ-9 or BDI) [8-11]</u>
	• In the past 2 weeks, how often have you been bothered by the following problems? (Options: a)Less than 1-2 days, b)several days, c)more than half the days, d)nearly every day, or e) not at all?) [12]
	  • Feeling down, depressed, or hopeless? [12]
	  • Feeling more irritated, grouchy, or angry than usual? [12]
	  • Feeling nervous, anxious, frightened, worried, or on edge? [12]
	  • Thoughts of actually hurting yourself? [12]
	  • Hearing things other people couldn't hear, such as voices even when no one was around? [12]
	  • Unpleasant thoughts, urges, or images that repeatedly enter your mind? [12]
	  • Using drugs or drinking at least 4 drinks of any kind of alcohol in a single day? [12]

Other	• Do you have anybody to help you solve economical, familial or sentimental problems? [1] • Will restrictions or isolation interfere with your ability to access or take your medications as normal? • Do you feel that restrictions or isolation will affect your ability to independently complete tasks of daily living? • Are you responsible for the caretaking of someone else which may be affected by restrictions or isolation? • Are there any other concerns that need to be considered?

**These questions do not represent a comprehensive list of possible harms experienced by PWTB during RIR. These probing questions may be tailored or altered based on individual circumstances. Individuals answering yes to one or more items in this list may warrant considerations for additional support, re-assessment of level of RIR, or other mitigation strategies to minimize potential patient harm.*

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