

Tuberculosis Contact Investigation Form

Submitted By: _____

Date: _____

DOH 343-059 March 2011

Case						Contact											
Name: (last) (first) (MI) (also known as)						Priority of exposed contact				Contact Investigation			Contact Risk Factors (Mark Y = Yes or N = No in chart below)				
						DOB: _____ Age: _____ RVCT: _____						(please refer to CI Instructions for definitions) <input type="checkbox"/> Category 1: Smear positive or cavitory chest x-ray <input type="checkbox"/> Category 2: Smear negative <input type="checkbox"/> Category 3: Suspect case				Date Identified: _____	
Morbidity Date: _____										Date Interviewed: _____							
County: _____ Comments: _____										Date of Evaluation: _____							
Type: <input type="checkbox"/> Pulmonary <input type="checkbox"/> Non Pulmonary CXR Results: <input type="checkbox"/> Cavitory <input type="checkbox"/> Noncavitory																	
Full Name of Contact	Date of Birth	*Exposure category	Household	< 5 years	Medical risk	Medical exposure	Cong Set	Enviro limits	5 - 15 years	CXR- prev TB	TST Results/ QFT-G Results			Current Chest X-Ray	Treatment of LTBI		**** Completion Date or Discontinued Due to:
											Prior Positive	Initial TST or QFT-G **	8 - 10 week retest				
1.											Date: _____ TST mm: _____ QFT-G: _____	Date: _____ TST mm: _____ QFT-G: _____	Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Yes Date: _____ Drug (s) _____ <input type="checkbox"/> No Reason: _____			
2.											Date: _____ TST mm: _____ QFT-G: _____	Date: _____ TST mm: _____ QFT-G: _____	Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Yes Date: _____ Drug (s) _____ <input type="checkbox"/> No Reason: _____			
3.											Date: _____ TST mm: _____ QFT-G: _____	Date: _____ TST mm: _____ QFT-G: _____	Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Yes Date: _____ Drug (s) _____ <input type="checkbox"/> No Reason: _____			
4.											Date: _____ TST mm: _____ QFT-G: _____	Date: _____ TST mm: _____ QFT-G: _____	Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Yes Date: _____ Drug (s) _____ <input type="checkbox"/> No Reason: _____			
5.											Date: _____ TST mm: _____ QFT-G: _____	Date: _____ TST mm: _____ QFT-G: _____	Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Yes Date: _____ Drug (s) _____ <input type="checkbox"/> No Reason: _____			

***Exposure Category**

H= High
M= Medium
L= Low

****Prior Positive**

(1) = Follow-up needed
(2) = Follow-up not needed

*****Quantiferon-GOLD Results**

(1) = Positive
(2) = Negative
(3) = Indeterminate

******Completion date or discontinued due to:**

(C) = Completed treatment
(D) = Died during treatment
(L) = Lost
(M) = Moved & Records Referred

(P) = Provider Discontinued Meds
(R) = Refused to continue
(T) = TB Disease Diagnosed