

# Individual Contact Form

Contact Information	Tests & Exposure	Treatment
First: _____ Middle: _____ Last: _____	TST # 1 Date placed: _____ Manufacturer: _____ Lot #: _____ Site: _____ Placed by: _____ Read by: _____ Date: _____ mm reading: _____	Treatment plan: ___ INH ___ RIF ___ 3HP ___ Other _____ ___ window period prophylaxis Declined treatment: ___ yes ___ no Date started: _____ Date completed: _____
DOB: _____ Age: _____ Race: _____	IGRA date: _____ result: _____ TST # 2 Date placed: _____ Manufacturer: _____ Lot #: _____ Site: _____ Placed by: _____ Read by: _____ Date: _____ mm reading: _____	If treatment not completed, why not: ___ TB disease developed ___ adverse reaction ___ died ___ patient stopped ___ lost to follow-up ___ provider decision ___ moved
Gender: _____ Address: _____ Phone: _____ County of Residence: _____	IGRA date: _____ result: _____ TST # 3 Date placed: _____ Manufacturer: _____ Lot #: _____ Site: _____ Placed by: _____ Read by: _____ Date: _____ mm reading: _____	Comments: _____
Country of Birth: _____ If not U.S., date of entry: _____ Have you ever had a positive tuberculin skin test or a positive blood test for tuberculosis? If yes, what date _____ Previous history of Active Tuberculosis: Yes ___ No ___ If yes, date: _____ Previous history of Latent Tuberculosis Infection (LTBI) Yes ___ No ___ Was treatment complete: Yes ___ No ___ Comments: _____	IGRA date: _____ result: _____ HIV: ___ negative ___ positive ___ declined Date of HIV test: _____	
Date of symptom screening: _____ <b>Symptoms/Signs</b> ___ Productive cough (>3 wks) ___ Hemoptysis ___ Fever/night sweats ___ Appetite loss ___ Unexplained fatigue ___ Shortness of breath ___ Chest pain ___ Unexplained weight Loss Source case NCEDSS#: _____	Date of CXR: _____ CXR results: _____ Date identified as a contact: _____ Hours of exposure: _____ Exposure site name: _____ Priority level: ___ High ___ Medium ___ Low Comments: _____	