

Last Name		First Name		MI
Patient Number				
Date of Birth		Month	Day	Year
Race				
Ethnicity: Hispanic or Latino Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female				
County of Residence				
County Number				

N.C. Department of Health and Human Services  
 Division of Public Health  
 Epidemiology Section • TB Control Program

# Nursing Record of Tuberculosis Contacts

Date Case Reported to Health Department \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Contact To:  Pulmonary TB Case: Smear  Pos  Neg  Not Done Culture  Pos  Neg  Not Done Specimen Source \_\_\_\_\_  
 Suspect, Not TB After Evaluation

Contact Information	Tests & Exposure	Treatment
Name:	TST # 1 Date placed: _____ mm reading: _____	Treatment plan: ___INH ___RIF ___3HP ___Other _____
Gender:	IGRA date: _____ result: _____	Declined treatment: ___yes ___no
DOB: Age:	TST # 2 Date placed: _____ mm reading: _____	Date started: _____
Race:	IGRA date: _____ result: _____	Date completed: _____
Address:	TST # 3 Date placed: _____ mm reading: _____	If treatment not completed, why not: ___ TB disease developed ___ adverse reaction ___ died ___ patient stopped ___ lost to follow-up ___ provider decision ___ moved
Phone:	IGRA date: _____ result: _____	
County of Residence:	HIV: ___neg. ___pos. ___declined Date of HIV test: _____	
Country of Birth: If not U.S., date of entry:	Date of CXR: _____ CXr result: _____	
Previous history of TB: ___yes ___no If yes, date: _____	Exposure site name: _____ Hours of exposure: _____	Comments:
Previous history of LTBI: ___yes ___no Date of TST/IGRA _____ MM reading: _____ Was treatment completed: ___yes ___no	Date identified as a contact: _____ Priority level: ___High ___Medium ___Low	
	Date of symptom screen: _____ ___Productive Cough < 3 weeks ___Fever/night sweats ___Unexplained fatigue ___Chest pain	___Hemoptysis ___Appetite loss ___Shortness of breath ___Unexplained weight loss

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