

Interjurisdictional TB Notification

TB Contact Investigation

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Referral Reason: Location, evaluation Completion of evaluation (evaluation initiated, but the person moved)

Date of Expected Arrival:

Referred for: Individual contact Expanded contact group

Referring TB Program requests Follow-Up Information returned: (check all that apply) Preliminary Final See Comments below

Client Information

Last Name: First Name: Middle Name:
Date of Birth: Sex at Birth: Gender Identity: Race: Ethnicity:
Country of Birth: Primary Language: Interpreter Needed?
New Address: City:
State/Province/Region: Zip Code: County:
Phone 1: Phone 2: Email:

Alternate Contact Name: Relationship: Phone:

Date of Last Exposure: Contact Priority: Type of Contact:

Index Case Sputum Smear Positive Index Case Sputum NAAT/Culture Positive Index Case Cavity on Radiology Index Case Drug Resistant:

Initial TB Test: Date: Result: TST mm: Report Attached:

8+ week Post-exposure Test: Date: Result: TST mm: Report Attached:

Radiology: Yes No Report Attached:

Treatment Status: MAR/DOT Log Attached:

Starting TB Infection Regimen: Date Started: Estimated Treatment Duration:

Date medication given for travel: # of doses in hand for travel: Prescription Given:

Side Effects, Adherence, or Administration Problems:

Comments:

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Client Information

Last Name:

First Name:

Date of Birth:

Follow-Up Information

Report Status: Date of Disposition: Reason Dispositioned:

If Disposition Other:

Evaluation: Evaluation Outcome:

Tests/Results: i TST/IGRA: Radiology: Smear(s): NAAT:
Most recent results are attached
(If not attached, please provide reason) Culture(s): Susceptibilities (if culture positive):

Treatment Status: MAR/DOT Log Attached: Completing TB Infection Regimen: Date Stopped:

If Patient Moved: Notified New Jurisdiction:

New Address: City:

State/Province/Region: Zip Code: County:

Phone 1: Phone 2: Email:

Comments: