Last Name	First Name	MI
Patient Number		
Date of Birth	Month / Day / Year	
Race: Select from list		
Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No ☐ Unknown		
Gender ☐ Male ☐ Female		
County of Residence: Select from list		
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: Gender:	TST # 1 Date placed: _____ mm reading: ejtlejteljteljel IGRA date: result:	Treatment plan: ___INH ___RIF ___3HP ___Other _____
DOB: Age: Race: Select from list	TST # 2 Date placed: _____ mm reading: IGRA date: result:	Declined treatment: ___yes ___no Date started: _____ Date completed: _____ If treatment not completed, why not: ___TB disease developed ___adverse reaction ___died ___patient stopped ___lost to follow-up ___provider decision ___moved
Address: Phone:	TST # 3 Date placed: _____ mm reading: IGRA date: result:	
County of Residence: Select from list	HIV: ___neg. ___pos. ___declined Date of HIV test:	
Country of Birth: If not U.S., date of entry:	Date of CXR: _____ CXR result:	Comments:
Previous history of TB: ___yes ___no If yes, date: _____ Previous history of LTBI: ___yes ___no Date of TST/IGRA _____MM reading: _____ Was treatment completed: ___yes ___no	Exposure site name: Hours of exposure: Date identified as a contact: _____ Priority level: ___High ___Medium ___Low	
	Date of symptom screen: _____ ___Productive Cough < 3 weeks ___Hemoptysis ___Fever/night sweats ___Appetite loss ___Unexplained fatigue ___Shortness of breath ___Chest pain ___Unexplained weight loss	

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