Individual Contact Form

<table>
<tr><th>Contact Information</th><th>Tests & Exposure</th><th>Treatment</th></tr>
<tr>
<td>First:
Middle:
Last:

DOB: Age:

Race:

Gender:
Address:
Phone:

County of Residence:

Country of Birth:
If not U.S., date of entry:</td>
<td>TST # 1 Date placed: ____________________
Manufacturer: ____________________
Lot #: ____________________
Site: ____________________
Placed by: ____________________
Read by: ____________________
Date:____________mm reading:____________

IGRA date:____________result:____________

TST # 2 Date placed: ____________________
Manufacturer: ____________________
Lot #: ____________________
Site: ____________________
Placed by: ____________________
Read by: ____________________
Date:____________mm reading:____________</td>
<td rowspan="2">Treatment plan:
____INH ____RIF ____3HP
____Other ____________________
____window period prophylaxis

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

Comments:</td>
</tr>
<tr>
<td>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:</td>
<td>IGRA date:____________result:____________

TST # 3 Date placed: ____________________
Manufacturer: ____________________
Lot #: ____________________
Site: ____________________
Placed by: ____________________
Read by: ____________________
Date:____________mm reading:____________

IGRA date:____________result:____________

HIV:
____negative ____positive ____declined
Date of HIV test:____________</td>
</tr>
<tr>
<td rowspan="2">Date of symptom screening: ________________

Symptoms/Signs

___Productive cough (>3 wks)
___Hemoptysis ___Fever/night sweats
___Appetite loss ___Unexplained fatigue
___Shortness of breath ___Chest pain
___Unexplained weight Loss

Source case NCEDSS#:

________________________________</td>
<td colspan="2">Date of CXR: ____________________
CXR results: ____
Date identified as a contact:____________________ Hours of exposure:____________
Exposure site name:____
Priority level: ____High ____Medium ____Low</td>
</tr>
<tr><td colspan="2">Comments:</td></tr>
</table>

DHHS 4097 (revised 01/2021)
TB Control (Review 01/2024)