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

Individual Contact Form

Contact Information

Name:

DOB: Age:

Race: Gender:

Address:

Phone:

County of Residence:

Country of Birth:
If not U.S., date of entry:

Previous history of TB: ___ yes ___ no
If yes, date: _____

Previous history of LTBI: ___ yes ___ no
Date of TST/IGRA _____
___ Positive ___ Negative _____ mm
Was treatment complete: ___ yes ___ no

Symptom screening done: ___ yes ___ no

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#: _____

Tests & Exposure

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: _____

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:

Date of CXR: _____

CXR results:

Exposure site name:

Hours of exposure:

Date identified as a contact: _____

Priority level:
___ High ___ Medium ___ Low

Treatment

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: