

# Form 2D: Smallpox Contact Tracing Form

OMB NO. 0920-0008  
Exp. Date: 06/2003

1. Last Name: _____ First Name: _____ MI: _____ Suffix: _____ Alias: _____					2. Street Address: _____			Apt #: _____							
3. City: _____ State: _____		4. Zip: _____		5. DOB: <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>		6. Age (Yrs): _____		7. Ethnicity: <input type="text" value="H"/> <input type="text" value="Non/H"/>		8. Race - Mark all that apply: <input type="text" value="AI/AN"/> <input type="text" value="Asian"/> <input type="text" value="B/AA"/> <input type="text" value="H/PI"/> <input type="text" value="O/U"/> <input type="text" value="White"/>		9. Sex: <input type="text" value="M"/> <input type="text" value="F"/>		20. Phone Number - Home: _____	
10. Height: _____	11. Size/Build: _____	12. Hair: _____	13. Complexion: _____	14. Pregnant?: <input type="text" value="Y"/> <input type="text" value="N"/> <input type="text" value="U"/>	15. Primary Language Spoken: _____		16. English Spoken: <input type="text" value="Y"/> <input type="text" value="N"/> <input type="text" value="U"/>		17. Name of Employer/School: _____				21. Phone Number - Cell: _____		
24. Exposure Dates:			25. Reported Case Number: _____			26. Date Interview of Reported Case: _____			18. Address of Employer/School: _____		19. Work Hours: _____		22. Phone Number - Work: _____		
Date of First Exposure: <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="Y"/> <input type="text" value="Y"/>			State: _____			<input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="Y"/> <input type="text" value="Y"/>							23. Phone Number - Other: _____		
Date of Last Exposure: <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="Y"/> <input type="text" value="Y"/>			30. Location, Epi Notes, and Other Relevant Information: _____												
27. Contact Type (Mark One)		28. Priority Code *													
Primary Contact															
OOJ Primary Contact															
27. (continued) Secondary Contact		29. Primary Contact Form 2D Number: _____			39. Disposition (Select One)										
OOJ Secondary Contact		(Complete only for Secondary Contacts) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			1. Located			2. Not Located							
<b>Case Contact Priority Codes *</b> 1 = Highest Priority - Case household contacts: All immediate family members; others spending > 3 hours in the household since case's onset of rash. 2 = Non household contacts with contact <6 feet with Case with rash for >= 3 hours. 3 = Non household contacts with contact <6 feet with Case with rash for < 3 hours. 4 = Non household contacts with contact >= 6 feet with Case with rash for >= 3 hours. 5 = Non household contacts with contact >= 6 feet with Case with rash for < 3 hours.		31. Date Form 2D Initiated: <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="Y"/> <input type="text" value="Y"/>		32. Initiated By: _____		1A Referred for Vaccination, Fever or Rash or Cough Not Present		2A Unable to Locate							
		33. Date of Contact Notification: <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="Y"/> <input type="text" value="Y"/>		34. Notified By: _____		1B Referred for Clinical Assessment, Fever or Rash or Cough Present		2B Moved From Jurisdiction, To: _____							
		35. Disposition Date: <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="Y"/> <input type="text" value="Y"/>		36. Dispo'ed By: _____		1C Already Hospitalized as Suspected Case, Fever or Rash or Cough Present		3. Deceased							
		37. Follow-up Assignment Date: <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="Y"/> <input type="text" value="Y"/>		38. Follow-up By: _____		1D Isolated, Not Vaccinated (within last 6 months), Fever or Rash or Cough Not Present		3A Smallpox Suspected							
						1E Previously Vaccinated (within last 6 months), Fever or Rash or Cough Not Present		3B Unrelated to Smallpox							
				Date of Vaccination: <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="Y"/> <input type="text" value="Y"/>		Reported Vaccination <input type="checkbox"/> Major <input type="checkbox"/> None		4. 4 Other: _____							
				Take Status: <input type="checkbox"/> Equivocal <input type="checkbox"/> Unknown		40. Smallpox Case ID: _____									
Form 2D Number - <b>A0001234</b>		Department of Health and Human Services Centers for Disease Control and Prevention			41. Reviewed By: _____		42. Comments: _____								

Public reporting burden of this collection of information is estimated to average \_\_\_ minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0008).