



CONTINUATION OF REPORT OF CONTACTS

Case Name		Date of Birth		SSN					
Last Name _____ First _____ Middle _____ Address _____ City _____ County _____ Country _____ Telephone No. Home _____ Work _____ Other _____		SSN _____ Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Race _____ <input type="checkbox"/> Hisp/Lat <input type="checkbox"/> Not Hisp/Lat DOB ____/____/____ BCG <input type="checkbox"/> Yes <input type="checkbox"/> No Relation to case: _____		Exp. Risk <input type="checkbox"/> Close <input type="checkbox"/> Casual <input type="checkbox"/> No contact was made Exp. Site <input type="checkbox"/> Household <input type="checkbox"/> Work site <input type="checkbox"/> Other Date contact broken ____/____/____		History of positive TST? <input type="checkbox"/> Yes <input type="checkbox"/> No TST Date ____/____/____ mm TST positive: <input type="checkbox"/> Yes <input type="checkbox"/> No CXR date ____/____/____ <input type="checkbox"/> norm. <input type="checkbox"/> abn. HIV Test Results <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> UNK		Treatment Started: ____/____/____ <input type="checkbox"/> TB disease <input type="checkbox"/> Treatment not started Treatment Stopped: ____/____/____ <input type="checkbox"/> Completed treatment <input type="checkbox"/> Contact chose to stop Number of months: ____ <input type="checkbox"/> Lost to follow-up Recommended ____ <input type="checkbox"/> Active TB developed <input type="checkbox"/> Provider decision Taken ____ <input type="checkbox"/> Contact moved follow-up UNK Clinic: _____ <input type="checkbox"/> Death <input type="checkbox"/> Adverse drug reaction	
Last Name _____ First _____ Middle _____ Address _____ City _____ County _____ Country _____ Telephone No. Home _____ Work _____ Other _____		SSN _____ Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Race _____ <input type="checkbox"/> Hisp/Lat <input type="checkbox"/> Not Hisp/Lat DOB ____/____/____ BCG <input type="checkbox"/> Yes <input type="checkbox"/> No Relation to case: _____		Exp. Risk <input type="checkbox"/> Close <input type="checkbox"/> Casual <input type="checkbox"/> No contact was made Exp. Site <input type="checkbox"/> Household <input type="checkbox"/> Work site <input type="checkbox"/> Other Date contact broken ____/____/____		History of positive TST? <input type="checkbox"/> Yes <input type="checkbox"/> No TST Date ____/____/____ mm TST positive: <input type="checkbox"/> Yes <input type="checkbox"/> No CXR date ____/____/____ <input type="checkbox"/> norm. <input type="checkbox"/> abn. HIV Test Results <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> UNK		Treatment Started: ____/____/____ <input type="checkbox"/> TB disease <input type="checkbox"/> Treatment not started Treatment Stopped: ____/____/____ <input type="checkbox"/> Completed treatment <input type="checkbox"/> Contact chose to stop Number of months: ____ <input type="checkbox"/> Lost to follow-up Recommended ____ <input type="checkbox"/> Active TB developed <input type="checkbox"/> Provider decision Taken ____ <input type="checkbox"/> Contact moved follow-up UNK Clinic: _____ <input type="checkbox"/> Death <input type="checkbox"/> Adverse drug reaction	
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COMMENTS: