Print Form

STATE OF CT TUBERCULOSIS CONTROL PROGRAM - CONTACT INVESTIGATION WORKSHEET (TB-5)

410 Capitol Avenue, MS #11TUB, P.O. Box 340308, Hartford, CT 06134-0308 Voice: (860) 509-7722 Fax:: (860) 509-7743

TUBERCULOSIS EPIDEMIOLOGIST: STATE CASE #

INTERVIEWER: _____

CASE INFORMATION:
NAME (LAST,FIRST, MI)_____ DOB:_____

FACILITY: _____

SITE OF DISEASE:_____INFECTIOUS PERIOD: START DATE _____/_____/_____ END DATE_____/_____/_____

DATE INTERVIEW INITIATED:_____

PHONE:_____

EXPOSURE SETTING CODES:
[01] HOUSEHOLD
[02] NON-HOUSEHOLD/FRIENDS/RELATIVES
[03] RESTAURANT/BAR
[04] CORRECTIONAL FACILITY
[05] SCHOOL/DAY CARE
[06] NURSING HOME
[07] SHELTER
[08] HOSPITAL/ACUTE CARE
[09] WORKSITE
[10] UNKNOWN
[11] OTHER
SPECIFY:_____

RISK FACTOR CODES FOR CONTACTS:
[A] AGE < 5
[B] IMMUNOCOMPROMISED
[C] CXR CONSISTENT W/ INACTIVE TB
[D] OTHER MEDICAL RISK

REPORT AND DATE:
DATE SENT: ____/____/_____
SENT TO: _____
DATE FINAL REPORT REC'D: ____/____/_____

CONTACT 1

CONTACT INFORMATION:
FIRST NAME:_____
LAST NAME:_____
ADDRESS:_____
_____
PHONE:_____
DOB: _____/_____/_____ GENDER:_____
RACE:_____ ETHNICITY:_____

EXPOSURE CODES:

RISK FACTOR CODES:

<8 WEEKS TST/QFT
☐ TST ☐ QFT
DATE:
_____/_____/_____
TST INDURATION:
_____MM
QFT RESULT:
☐ POSITIVE
☐ NEGATIVE
☐ INDETERMINATE

>8 WEEKS TST/QFT
☐ TST ☐ QFT
DATE:
_____/_____/_____
TST INDURATION:
_____ MM
QFT RESULT:
☐ POSITIVE
☐ NEGATIVE
☐ INDETERMINATE

CXR
DATE:_____/_____/_____
☐ NORMAL
☐ ABNORMAL-CONSISTENT WITH INACTIVE TB
☐ ABNORMAL-CONSISTENT WITH TB DISEASE

HIV TEST DATE:
_____/_____/_____
RESULTS: ☐ POS ☐ NEG
☐ INDETERMINATE

TREATMENT
DATE STARTED:
_____/_____/_____
DATE STOPPED:
_____/_____/_____
REGIMEN:
☐ INH ☐ RIF
☐ OTHER_____
☐ NO TREATMENT
REASON NOT TREATED:

PROVIDER
NAME:_____
ADDRESS:_____
_____
_____
PHONE:_____

CONTACT 2

CONTACT INFORMATION:
FIRST NAME:_____
LAST NAME:_____
ADDRESS:_____
_____
PHONE:_____
DOB: _____/_____/_____ GENDER:_____
RACE:_____ ETHNICITY:_____

EXPOSURE CODES:

RISK FACTOR CODES:

<8 WEEKS TST/QFT
☐ TST ☐ QFT
DATE:
_____/_____/_____
TST INDURATION:
_____MM
QFT RESULT:
☐ POSITIVE
☐ NEGATIVE
☐ INDETERMINATE

>8 WEEKS TST/QFT
☐ TST ☐ QFT
DATE:
_____/_____/_____
TST INDURATION:
_____ MM
QFT RESULT:
☐ POSITIVE
☐ NEGATIVE
☐ INDETERMINATE

CXR
DATE:_____/_____/_____
☐ NORMAL
☐ ABNORMAL-CONSISTENT WITH INACTIVE TB
☐ ABNORMAL-CONSISTENT WITH TB DISEASE

HIV TEST DATE:
_____/_____/_____
RESULTS: ☐ POS ☐ NEG
☐ INDETERMINATE

TREATMENT
DATE STARTED:
_____/_____/_____
DATE STOPPED:
_____/_____/_____
REGIMEN:
☐ INH ☐ RIF
☐ OTHER_____
☐ NO TREATMENT
REASON NOT TREATED:

PROVIDER
NAME:_____
ADDRESS:_____
_____
_____
PHONE:_____

CONTACT 3

CONTACT INFORMATION:
FIRST NAME:_____
LAST NAME:_____
ADDRESS:_____
_____
PHONE:_____
DOB: _____/_____/_____ GENDER:_____
RACE:_____ ETHNICITY:_____

EXPOSURE CODES:

RISK FACTOR CODES:

<8 WEEKS TST/QFT
☐ TST ☐ QFT
DATE:
_____/_____/_____
TST INDURATION:
_____MM
QFT RESULT:
☐ POSITIVE
☐ NEGATIVE
☐ INDETERMINATE

>8 WEEKS TST/QFT
☐ TST ☐ QFT
DATE:
_____/_____/_____
TST INDURATION:
_____ MM
QFT RESULT:
☐ POSITIVE
☐ NEGATIVE
☐ INDETERMINATE

CXR
DATE:_____/_____/_____
☐ NORMAL
☐ ABNORMAL-CONSISTENT WITH INACTIVE TB
☐ ABNORMAL-CONSISTENT WITH TB DISEASE

HIV TEST DATE:
_____/_____/_____
RESULTS: ☐ POS ☐ NEG
☐ INDETERMINATE

TREATMENT
DATE STARTED:
_____/_____/_____
DATE STOPPED:
_____/_____/_____
REGIMEN:
☐ INH ☐ RIF
☐ OTHER_____
☐ NO TREATMENT
REASON NOT TREATED:

PROVIDER
NAME:_____
ADDRESS:_____
_____
_____
PHONE:_____

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CASE INFORMATION: DOB: STATE CASE #
NAME (LAST,FIRST, MI)

CONTACT INFORMATION: FIRST NAME:________ LAST NAME:________ ADDRESS:________ ________ PHONE:________ DOB: ___/___/____ GENDER:______ RACE:______ ETHNICITY:______	EXPOSURE CODES: RISK FACTOR CODES:	<8 WEEKS TST/QFT ☐ TST ☐ QFT DATE: ___/___/____ TST INDURATION: ________MM QFT RESULT: ☐ POSITIVE ☐ NEGATIVE ☐ INDETERMINATE	>8 WEEKS TST/QFT ☐ TST ☐ QFT DATE: ___/___/____ TST INDURATION: ________ MM QFT RESULT: ☐ POSITIVE ☐ NEGATIVE ☐ INDETERMINATE	CXR DATE:___/___/____ ☐ NORMAL ☐ ABNORMAL-CONSISTENT WITH INACTIVE TB ☐ ABNORMAL-CONSISTENT WITH TB DISEASE HIV TEST DATE: ___/___/____ RESULTS: ☐ POS ☐ NEG ☐ INDETERMINATE	TREATMENT DATE STARTED: ___/___/____ DATE STOPPED: ___/___/____ REGIMEN: ☐ INH ☐ RIF ☐ OTHER______ ☐ NO TREATMENT REASON NOT TREATED:	PROVIDER NAME:________ ADDRESS:________ ________ ________ PHONE:________
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