

1. Last Name	First Name	MI
2. Patient Number		
3. Date of Birth	Month	Day Year
4. Race <input type="checkbox"/> 1. American Indian/Alaska Native <input type="checkbox"/> 2. Asian <input type="checkbox"/> 3. Black/African American <input type="checkbox"/> 4. Native Hawaiian/ Other Pacific Islander <input type="checkbox"/> 5. White <input type="checkbox"/> 6. Unknown		
Ethnicity: Hispanic or Latino Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
5. Gender <input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female		
6. County of Residence		
8. Contact To: <input type="checkbox"/> Pulmonary TB Case: Smear <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not Done Culture <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not Done Specimen Source _____ <input type="checkbox"/> Suspect, Not TB After Evaluation		

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

Nursing Record of Tuberculosis Contacts

7. Date Case Reported to Health Department ____/____/____

Contact Information	Tests & Exposure	Treatment
Name:	TST # 1 Date placed: _____ mm reading: _____ IGRA date: _____ result: _____	Treatment plan: ___ INH ___ RIF ___ Other _____ ___ window period prophylaxis
DOB: Age:	TST # 2 Date placed: _____ mm reading: _____ IGRA date: _____ result: _____	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
Race: Gender:	Address:	
Address:	TST # 3 Date placed: _____ mm reading: _____ IGRA date: _____ result: _____	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
County of Residence:	HIV: ___ neg. ___ pos. ___ declined Date of HIV test: _____	
Country of Birth: If not U.S., date of entry:	Date of CXR: _____ CXr result: _____ Exposure site name: _____ Hours of exposure: _____	
Previous history of TB: ___ yes ___ no If yes, date: _____	Date identified as a contact: _____ Priority level: ___ High ___ Medium ___ Low	
Previous history of LTBI: ___ yes ___ no Date of TST/IGRA _____ MM reading: _____ Was treatment completed: ___ yes ___ no	Comments:	
Symptom screening done: ___ yes ___ no		

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