1. Last Name	First Name		MI
2. Patient Number			
3. Date of Birth	Month	Day	Year

4. Race ☐ 1. American Indian/Alaska Native ☐ 2. Asian ☐ 3. Black/African American ☐ 4. Native Hawaiian/ Other Pacific Islander ☐ 5. White ☐ 6. Unknown

Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No ☐ Unknown

5. Gender ☐ 1. Male ☐ 2. Female

6. County of Residence

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 _____/_____/_____

8. Contact To: ☐ Pulmonary TB Case: Smear ☐ Pos ☐ Neg ☐ Not Done Culture ☐ Pos ☐ Neg ☐ Not Done Specimen Source _____
☐ Suspect, Not TB After Evaluation

Contact Information	Tests & Exposure	Treatment
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 _____ MM reading: _____ Was treatment completed: ___ yes ___ no	TST # 1 Date placed: _____ mm reading: IGRA date: _____ result: _____ TST # 2 Date placed: _____ mm reading: IGRA date: _____ result: _____ TST # 3 Date placed: _____ mm reading: IGRA date: _____ result: _____ HIV: ___ neg. ___ pos. ___ declined Date of HIV test: Date of CXR: _____ CXR result: Exposure site name: Hours of exposure: Date identified as a contact: _____ Priority level: ___ High ___ Medium ___ Low Date of symptom screen: _____ ___ Productive Cough < 3 weeks ___ Hemoptysis ___ Fever/night sweats ___ Appetite loss ___ Unexplained fatigue ___ Shortness of breath ___ Chest pain ___ Unexplained weight loss	Treatment plan: ___ INH ___ RIF ___ 3HP ___ Other _____ 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:

Contact Information	Tests & Exposure	Treatment
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 _____ MM reading: _____ Was treatment completed: ___ yes ___ no	TST # 1 Date placed: _____ mm reading: IGRA date: _____ result: _____ TST # 2 Date placed: _____ mm reading: IGRA date: _____ result: _____ TST # 3 Date placed: _____ mm reading: IGRA date: _____ result: _____ HIV: ___ neg. ___ pos. ___ declined Date of HIV test: Date of CXR: _____ CXR result: Exposure site name: Hours of exposure: Date identified as a contact: _____ Priority level: ___ High ___ Medium ___ Low Date of symptom screen: _____ ___ Productive Cough < 3 weeks ___ Hemoptysis ___ Fever/night sweats ___ Appetite loss ___ Unexplained fatigue ___ Shortness of breath ___ Chest pain ___ Unexplained weight loss	Treatment plan: ___ INH ___ RIF ___ 3HP ___ Other _____ 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:

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Contact Information	Tests & Exposure	Treatment
Name:	TST # 1 Date placed: _____ mm reading: IGRA date: _____ result: _____	Treatment plan: ___ INH ___ RIF ___ 3HP ___ Other _____
DOB: Age: Race: Gender:	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
Address: Phone:	TST # 3 Date placed: _____ mm reading: IGRA date: _____ result: _____	
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:	
Previous history of TB: ___ yes ___ no If yes, date: _____ Previous history of LTBI: ___ yes ___ no Date of TST/IGRA _____ MM reading: _____ Was treatment completed: ___ yes ___ no	Exposure site name: Hours of exposure: Date identified as a contact: _____ Priority level: ___ High ___ Medium ___ Low	Comments:
	Date of symptom screen: _____ ___ Productive Cough < 3 weeks ___ Hemoptysis ___ Fever/night sweats ___ Appetite loss ___ Unexplained fatigue ___ Shortness of breath ___ Chest pain ___ Unexplained weight loss	

Contact Information	Tests & Exposure	Treatment
Name:	TST # 1 Date placed: _____ mm reading: IGRA date: _____ result: _____	Treatment plan: ___ INH ___ RIF ___ 3HP ___ Other _____
DOB: Age: Race: Gender:	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
Address: Phone:	TST # 3 Date placed: _____ mm reading: IGRA date: _____ result: _____	
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:	
Previous history of TB: ___ yes ___ no If yes, date: _____ Previous history of LTBI: ___ yes ___ no Date of TST/IGRA _____ MM reading: _____ Was treatment completed: ___ yes ___ no	Exposure site name: Hours of exposure: Date identified as a contact: _____ Priority level: ___ High ___ Medium ___ Low	Comments:
	Date of symptom screen: _____ ___ Productive Cough < 3 weeks ___ Hemoptysis ___ Fever/night sweats ___ Appetite loss ___ Unexplained fatigue ___ Shortness of breath ___ Chest pain ___ Unexplained weight loss	