VPD-20
Revised August 2017

Tuberculosis Contact Investigation Form

Please use mm/dd/yyyy for all dates

INDEX CASE NBS Case Number: **ESTATE:** **Date Counted by VIDOH:** _____/_____/_____ **Status:** ❑ Confirmed Case ❑ Suspect

Name: _____
Last First M.I.

Birth Date: _____/_____/_____ **Country of Birth:** _____

Living Arrangement: _____

_____

Jobs/Schools/Activities: _____

_____

Site of Disease: ❑ pulmonary ❑ extrapulmonary/respiratory ❑ extrapulmonary/not respiratory

Bacteriology: ❑ sputum smear positive ❑ no positive smear or culture from sputum
❑ sputum smear negative or unknown, sputum culture positive

Symptoms: Onset: _____/_____/_____ Cough? ❑ yes ❑ no

Chest X-ray: ❑ negative for active TB ❑ abnormal, cavitary ❑ abnormal, non-cavitary

Estimated Level of Infectiousness: ❑ high ❑ low **Treatment started:** _____/_____/_____

Estimated Infectious Period: _____/_____/_____ — _____/_____/_____

INH Susceptibility: ❑ susceptible ❑ resistant ❑ unknown

CONTACT

Name: _____

Birth Date: _____/_____/_____ **Sex**: _____ **County**: _____

Address: _____

Phone Number(s): _____

Country of Birth: ❑ U.S. ❑ foreign-born **Arrival in U.S.**: mo. _____/ yr. _____

Exposure Setting: ❑ household ❑ work/school ❑ leisure ❑ other

Exposure Risk: ❑ close ❑ other than close

Relationship to Index Case: _____

Date of Last Exposure: _____/_____/_____ **8-Week Follow-up TST Due**: _____/_____/_____

Follow-up Priority: ❑ high (age <5 yrs, medical risk, intense exposure) ❑ medium

Comments:

MEDICAL HISTORY

BCG: ❑ yes ❑ no/unknown

Previous TST: ❑ yes ❑ no
Date: _____/_____/_____
Result: _____mm

Prior TB Disease:
❑ yes (year:_____) ❑ no

Completed Treatment:
❑ for TB disease
❑ for latent TB infection
❑ no/unknown

Relevant Medical Condition:
❑ yes _____
❑ no

CURRENT EVALUATION AND TREATMENT FOR LTBI

TB Symptoms: ❑ yes _____ ❑ no

TST: Initial Date: _____/_____/_____ Result: _____mm
Re-test required? ❑ yes ❑ no
Final Date: _____/_____/_____ Result: _____mm

Chest X-Ray: Date: _____/_____/_____ Result: ❑ abnormal, consistent with active TB
❑ negative for active TB

TB Disease: ❑ yes ❑ no ❑ unknown

Started Therapy for LTBI:
❑ yes, date: _____/_____/_____ ❑ no

LTBI Meds: INH RIF Other

Physician/Clinic:

Name: _____

Birth Date: _____/_____/_____ **Sex**: _____ **County**: _____

Address: _____

Phone Number(s): _____

Country of Birth: ❑ U.S. ❑ foreign-born **Arrival in U.S.**: mo. _____/ yr. _____

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❑ for latent TB infection
❑ no/unknown

Relevant Medical Condition:
❑ yes _____
❑ no

TB Symptoms: ❑ yes _____ ❑ no

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❑ yes, date: _____/_____/_____ ❑ no

LTBI Meds: INH RIF Other

Physician/Clinic:

Completed by: **Agency:** **Phone:** **Date Submitted:**

Name: _____

Birth Date: _____/_____/_____ **Sex**: _____ **County**: _____

Address: _____

Phone Number(s): _____

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