

Novel and Pandemic Influenza A Virus Infection Contact Trace Forward Form

**For Investigation of Contacts Potentially Exposed to Persons with Suspected or
Confirmed Pandemic or Novel Influenza A Virus Infection**

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0004).

**Novel and Pandemic Influenza A Virus Infection Contact Trace Forward Form –
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State/Local case ID# _____ Date of case-patient illness onset _____
 CDC case ID # _____ Date of case-patient illness notification _____
 Contact Group ID# _____

****NOTE: A contact of a case-patient is anyone who came within 1 meter or 3 feet of the case-patient, by for example, taking care of, speaking to, directly touching, or handling case-patient items****

Close Contacts—Family, friends, and other persons who live with or take care of the case-patient

Last Name	First Name	DOB	Age	Gender	Relationship with case*	Telephone	Email	Address	Date of Last Contact with Case	Under Follow-up
				M F						
				M F						
				M F						
				M F						
				M F						
				M F						
				M F						

* Family member(specify), friend, other(specify)

Medical Contacts—Doctors, nurses, or others healthcare workers

Last Name	First Name	DOB	Age	Gender	Relationship with case**	Telephone	Email	Address	Date of Last Contact with Case	Under Follow-up
				M F						
				M F						
				M F						
				M F						
				M F						
				M F						

** Specify type of type of healthcare worker

Work or School Contacts—Co-workers, classmate, employers, teachers, or other members of workplace or school										
Last Name	First Name	DOB	Age	Gender	Relationship with Case***	Telephone	Email	Address	Date of Last Contact with Case	Under Follow-up
				M F						
				M F						
				M F						
				M F						
				M F						
				M F						

** specify co-worker, employee, employer, etc