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OMB Approved

Control No 0920-XXXX

Exp Date: XX/XX/XXXX

**TB Contact/Source Investigation (CI/SI) Notification**

Telephone: (619) 542-4013 Fax: (404) 471-8905

¹Referring Jurisdiction: ¹Date sent:

City County State

¹Contact person: ¹Telephone. Ext. Fax:

Referring Agency: E-Mail Address:

Index Patient Information for:  Contact Investigation  Source Investigation

**Index Patient Information**

¹**Name**: Sex:  M  F

Paternal Maternal First Middle

Alias: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB or Age: \_\_\_\_\_\_\_\_\_\_\_ Parent’s Name (If child for SI): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number Street Apt City

Home Phone: Cell:

County State Zip code

Check if patient/parent not currently at home. Current location: Tel.:

Contact person: Name: Home Phone: Cell:

Relationship: E-Mail Address:

**Clinical Information:**

Site (s) of disease:  Pulmonary  Meningeal  Disseminated  Other(s), specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date: \_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- | --- | --- | --- | --- |
| 2**Date of collection** | 2**Specimen type** | 2**Smear** | **Culture** | **Susceptibility** | | |
| **Drug** | **Sens** | **Res**  **Comments:** |
|  |  |  |  | INH |  |  |
|  |  |  |  | RIF |  |  |
|  |  |  |  | EMB |  |  |
|  |  |  |  | PZA |  |  |

HIV  Diabetes  No Symptoms  Symptoms, specify:

**Primary Address of Exposure**

**Contacts/Possible Sources**

**Address:**

**Country** Telephone:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **DOB or Age** | **Relationship to Index Patient** | **Date Last Exposure** | **Phone #**  (H=Home; C=Cell) | **Risk Factors** | | | **Sx** | **On Tx** |
| ≤5 y/o | HIV/ AIDS | Immunosuppression |
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**Other Address of Exposure**

**Address:**

**Country** Telephone:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **DOB or Age** | **Relationship to Index Patient** | **Date Last Exposure** | **Phone #**  (H=Home; C=Cell) | **Risk Factors** | | | **Sx** | **On Tx** |
| ≤5 y/o | HIV/ AIDS | Immunosuppression |
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**Comments:**

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 Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-XXXX

**1. Fields required to initiate the referral process**

2. Please send imaging and laboratory reports as attachments.

3. Please attach additional information, as needed.

Centers for Disease Control and Prevention

Division of Global Migration and Quarantine

E-Mail: [curetb@cdc.gov](mailto:curetb@cdc.gov)