

TB Contact/Source Investigation (CI/SI) Notification

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



¹Referring Jurisdiction: _____
City _____ County _____ State _____
¹Date sent: _____

¹Contact person: _____
¹Telephone: _____ Ext. _____ Fax: _____

Referring Agency: _____ E-Mail Address: _____

Index Patient Information for: Contact Investigation Source Investigation

Index Patient Information

¹Name: _____ Sex: M F
Paternal Maternal First Middle

Alias: _____ DOB or Age: _____ Parent's Name (If child for SI): _____

Number _____ Street _____ Apt _____ City _____
County _____ State _____ Zip code _____ Home Phone: _____ Cell: _____

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: _____

Date of	Specimen type	Smear	Culture	Susceptibility			Treatment:	Start Date:
				Drug	Sens	Res		
Comments:				INH	<input type="checkbox"/>	<input type="checkbox"/>		
				RIF	<input type="checkbox"/>	<input type="checkbox"/>		
				EMB	<input type="checkbox"/>	<input type="checkbox"/>		
				PZA	<input type="checkbox"/>	<input type="checkbox"/>		

HIV Diabetes No Symptoms Symptoms, specify: _____

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		
					<input type="checkbox"/>			<input type="checkbox"/>	
					<input type="checkbox"/>			<input type="checkbox"/>	
					<input type="checkbox"/>			<input type="checkbox"/>	
					<input type="checkbox"/>			<input type="checkbox"/>	
					<input type="checkbox"/>			<input type="checkbox"/>	

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		
					<input type="checkbox"/>			<input type="checkbox"/>	
					<input type="checkbox"/>			<input type="checkbox"/>	
					<input type="checkbox"/>			<input type="checkbox"/>	
					<input type="checkbox"/>			<input type="checkbox"/>	
					<input type="checkbox"/>			<input type="checkbox"/>	

Comments: _____

- Fields required to initiate the referral process
- Please send imaging and laboratory reports as attachments.
- Please attach additional information, as needed.

Centers for Disease Control and Prevention
Division of Global Migration and Quarantine
E-Mail: curetb@cdc.gov

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