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| **Contact Investigation Form: Non-TB Illness****Unaccompanied Children’s Program****Office of Refugee Resettlement (ORR)** |
| **General Information**  |
| **Child** | Last name: | First name: |
| DOB:   | A#: | Gender: |
| **Healthcare Provider**  | Name:  **MD / DO / PA / NP**  | Phone number: | Clinic or Practice: |
| Street address: | City or Town: | State: | Date evaluated:  |
| **Program**  | Name of program staff with child: | Program name: |
| **Exposure Information**  |
| **Illness of exposure:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date of first exposure to person with illness:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_ |
| **When did exposure occur?** | * Before arrival at ORR program
 | * After arrival at ORR program
 |
| **Describe exposure to person with illness (e.g., child spent 4 hours a day in class for 5 days):** |
| **This contact** (check all that apply): | * is an infant (less than 1 year old)
 | * is pregnant
 |
| * has an immunocompromising condition (e.g., HIV, cancer, on immunosuppressive medication)
 |
| **Interventions**  |
| **Select *No* or *Yes* for each question below. If *Yes*, enter the information in the corresponding table.**  |
| **Medications given:** | * No
 | * Yes
 |
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| --- | --- | --- | --- | --- | --- |
| **Name** | **Date started** | **Date discontinued** | **Dose** | **Directions** | **Psychotropic** |
|  |  |  |  |  | * No
 | * Yes
 |
|  |  |  |  |  | * No
 | * Yes
 |

 |
| **Immunizations given:**  | * No
 | * Yes
 |
|

|  |  |
| --- | --- |
| **Vaccine name** | **Date given** |
|  |  |
|  |  |

 |
| **Lab testing performed** | * No
 | * Yes
 |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Illness tested** | **Collection date** | **Specimen type (e.g., Serum)** | **Test name** | **Result** |
|  |  |  |  |  |
|  |  |  |  |  |

 |
| **Actions Taken and Outcome**  |
| **Was child quarantined?** | * No
 | * Yes, **was discharge delayed?**
 | * No
 | * Yes
 |
| **Outcome of ORR contact investigation** (Check one): |
| * Cleared
 | * Incomplete evaluation
 | * Diagnosed with illness (Complete Medical Complaint form)
 |
| **Comments:** |
|  |

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