OMB Control No: 0970-XXXX
Expiration date: XX/XX/XXXX

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

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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