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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 | | | | | | | | | | | | | | | |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **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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