

General Land Contact Investigation Outcome Reporting Form
FAX completed form to the CDC at 404.718.2158; For questions, call 404.639.7147

1. TRAVEL INFORMATION					
CDC/QARS ID#	Arrival date	Departure city, state	Arrival city, state	Point of Entry	<input type="checkbox"/> Train <input type="checkbox"/> Bus Company/Route No:
2. INDEX CASE CLINICAL AND LAB INFORMATION					
3. PASSENGER CONTACT INFORMATION					
Last name, First name		Address/Phone/email		Gender	DOB (mm/dd/yy)/Age (yrs)
4. CONTACT /INTERVIEW INFORMATION					
Were you able to contact this person?					
<input type="checkbox"/> No, why not? <input type="checkbox"/> Incorrect locating information <input type="checkbox"/> No longer at temporary address but still in U.S. <input type="checkbox"/> No response					
<input type="checkbox"/> Returned to country of residence <input type="checkbox"/> Didn't attempt follow-up <input type="checkbox"/> Other, specify _____ (Stop here)					
<input type="checkbox"/> Yes, date contacted: ___/___/___					
Was contact interviewed?					
<input type="checkbox"/> No, why not? <input type="checkbox"/> Declined <input type="checkbox"/> Lives in different jurisdiction, specify _____					
<input type="checkbox"/> Other, specify _____ (Stop here)					
<input type="checkbox"/> Yes; actual/verified seat/location # _____					
Was this person a known close contact of the index case outside of this travel (e.g. family member)? <input type="checkbox"/> No <input type="checkbox"/> Yes					
5. IMMUNITY					
Vaccination or history of disease: <input type="checkbox"/> Not vaccinated <input type="checkbox"/> Vaccinated, date of most recent dose: ___/___/___					
<input type="checkbox"/> History of disease <input type="checkbox"/> Immunity established by serology <input type="checkbox"/> Unknown					
6. HEALTH SINCE TRAVEL					
Did contact report any signs or symptoms? <input type="checkbox"/> No <input type="checkbox"/> Yes; check all that apply:					
<input type="checkbox"/> Fever (Max temp measured _____°C/F) <input type="checkbox"/> Cough <input type="checkbox"/> Rash <input type="checkbox"/> Coryza <input type="checkbox"/> Conjunctivitis					
<input type="checkbox"/> Sore throat <input type="checkbox"/> Swollen glands <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Jaundice <input type="checkbox"/> Headache <input type="checkbox"/> Neck stiffness					
<input type="checkbox"/> Unusual bleeding <input type="checkbox"/> Decreased consciousness <input type="checkbox"/> Difficulty breathing/shortness of breath					
<input type="checkbox"/> Recent onset of focal weakness and/or paralysis <input type="checkbox"/> Other, specify _____					
7. PUBLIC HEALTH INTERVENTION					
Did contact receive prophylaxis for this exposure?					
<input type="checkbox"/> No, why not?					
<input type="checkbox"/> Outside window for prophylaxis <input type="checkbox"/> Within window for prophylaxis but declined <input type="checkbox"/> Other, specify _____					
<input type="checkbox"/> Yes, please indicate what s/he received and include the date(s):					
<input type="checkbox"/> Antimicrobial drug; specify _____, date received: ___/___/___ <input type="checkbox"/> Vaccination; date received: ___/___/___					
<input type="checkbox"/> Immunoglobulin; date received: ___/___/___ <input type="checkbox"/> Other, specify _____; date received: ___/___/___					
8. DIAGNOSIS					
Was this person diagnosed with the disease in question?					
<input type="checkbox"/> No					
<input type="checkbox"/> Unknown, why? <input type="checkbox"/> Declined medical evaluation <input type="checkbox"/> Not interviewed after incubation period					
<input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Other, specify _____					
<input type="checkbox"/> Yes, how was diagnosis made? (Check all that apply)					
<input type="checkbox"/> IgM <input type="checkbox"/> Paired IgG <input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Epi-linked <input type="checkbox"/> Clinical diagnosis <input type="checkbox"/> Other, specify _____					
Check any of the following potential exposures this person may have had recently for the disease in question:					
<input type="checkbox"/> Exposed to a confirmed case besides the index case					
<input type="checkbox"/> Other, specify _____					
What was the official diagnosis for this person (e.g. confirmed pertussis, active TB, LTBI)? _____					
9. COMMENTS					

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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 0920-0900.