

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

DGMH ID#	Arrival date	Departure city, state, country	Arrival city, state, country	Port of Entry or Border Patrol Sector:	Train Bus Other: _____ Company/Route No: _____
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2. INDEX CASE

ILLNESS SUSPECTED/PROBABLE/CONFIRMED (CIRCLE ONE): _____
CLINICAL INFORMATION:

LABORATORY INFORMATION:

3. INFORMATION FOR EXPOSED (CONTACT) PASSENGER/TRAVELER

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?
No, due to: Incorrect locating information No longer at temporary address but still in U.S. No response
Returned to country of residence Didn't attempt follow-up Other, specify _____ (Stop here)
Yes, date contacted: ___/___/___
Was contact interviewed?
No, due to: Declined Lives in different jurisdiction, specify _____
Other, specify _____ (Stop here)
Yes; actual/verified seat/location # _____ **Unknown Does not apply**
Was this person a known close contact of the index case outside of this travel (e.g. family member)? No
Yes: specify _____

5. VACCINATION STATUS

Vaccination or history of disease: Not vaccinated Vaccinated, date of most recent dose: ___/___/___ Does not apply
Vaccine type (if relevant: _____)
History of disease: Year: ___ Antibody status established by serology: Year: ___ Unknown

6. HEALTH SINCE TRAVEL

Did contact report any signs or symptoms? No Yes: check all that apply:
Fever (Max temp measured ___°C/F) Cough Rash Coryza Conjunctivitis
Sore throat Swollen glands Vomiting Diarrhea Jaundice Headache Neck stiffness
Unusual bleeding Decreased consciousness Difficulty breathing/shortness of breath
Recent onset of focal weakness and/or paralysis Other, specify _____

7. PUBLIC HEALTH INTERVENTION

Did contact receive prophylaxis for this exposure?
No, due to:
Outside window for prophylaxis Within window for prophylaxis but declined Other, specify _____
Yes, please indicate what s/he received and include the date(s):
Antimicrobial drug; specify _____, date received: ___/___/___ Vaccination; date received: ___/___/___
Immunoglobulin; date received: ___/___/___ Other, specify _____; date received: ___/___/___

8. DIAGNOSIS

Was this person diagnosed with the disease in question?
No
Unknown, why? Declined medical evaluation Not interviewed after incubation period
Lost to follow-up Other, specify _____
Yes, how was diagnosis made? (Check all that apply)
IgM Paired IgG PCR Culture Epi-linked Clinical diagnosis Other, specify _____
Check any of the following potential exposures this person may have had recently for the disease in question:
Exposed to a confirmed case besides the index case
Other, specify _____

What was the official diagnosis for this person (e.g. confirmed pertussis, active TB, LTBI)? _____

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9. COMMENTS

Public reporting burden of this collection of information is estimated to average 5 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 H21-8, Atlanta, Georgia 30333; ATTN: PRA 0920-0900.