Last Name	First Name	MI
Patient Number		
Date of Birth	Month / Day / Year	
County of Residence Date Reported to LHD: __/__/____		

N.C. Department of Health and Human Services
Division of Public Health
Epidemiology Section • TB Control Program

Nursing Record of Tuberculosis Contacts

Contact To: ☐ Pulmonary TB Case: Smear ☐ Pos ☐ Neg ☐ Not Done Culture ☐ Pos ☐ Neg ☐ Not Done Specimen Source: _____
☐ Suspect, Not TB After Evaluation

Contact Information	Tests & Exposure	Treatment
Name: DOB: Age: Race: Gender: County of residence: Address: Phone: Country of birth: If not U.S., date of entry: Previous history of TB? __ Yes __ No If yes, date: _____ Treatment: _____ Previous history of LTBI? __ Yes __ No If yes, date: _____ Treatment: _____ Date identified as a contact: Priority level: __ High __ Medium __ Low Exposure setting: _____	Test #1: __ TST __ IGRA Date of test: Date of result: Result: Test #2: __ TST __ IGRA Date of test: Date of result: Result: Date of CXR: CXR result: Date of symptom screen: __ Productive cough >3 weeks __ Hemoptysis __ Fever/night sweats __ Unexplained fatigue __ Chest pain __ Shortness of breath __ Unexplained weight loss (__lbs) __ Appetite loss	Treatment plan: Latent TB __ INH __ RIF __3HP __ Other Date started: Date completed: If treatment not started/completed: __ Developed active TB __ Adverse reaction __ Died __ Patient decision __ Lost to follow up __ Provider decision __ Moved __ Other Comments:

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