TB Contact Investigation **Final 502** Form

Index Case ID# ________________ **District** ________________ **Nurse Case Manager Name** ________________ **Nurse Case Manager Phone #** ________________

Date Case/Presumptive Reported to Local Health Dept. ____________________ **Date Contact Investigation Initiated** ____________________

Type of Investigation: ☐ Contact ☐ Source Case **Type of Case** ☐ Pulmonary Smear Pos. ☐ Pulmonary Culture Pos. ☐ Pulmonary Smear Neg. ☐ Extrapulmonary ☐ Clinical ☐ GeneXpert Pos.

Infectious Period	
Start Date: ________	End Date: ________

Contact Last Name: ____________________ **First Name**: ____________________

DOB: ______________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ______________ ☐ Hispanic ☐ Not Hispanic

Address: ____

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________________

Date of last exposure to the case: ________________________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: __________ __________ __________

Hx of **Prior TB**: ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment**: ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: __________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: __________

Date Tx Started: __________

Date Tx Stopped: __________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

---

Contact Last Name: ____________________ **First Name**: ____________________

DOB: ______________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ______________ ☐ Hispanic ☐ Not Hispanic

Address: ____

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________________

Date of last exposure to the case: ________________________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: __________ __________ __________

Hx of **Prior TB**: ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment**: ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: __________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: __________

Date Tx Started: __________

Date Tx Stopped: __________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

---

Contact Last Name: ____________________ **First Name**: ____________________

DOB: ______________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ______________ ☐ Hispanic ☐ Not Hispanic

Address: ____

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________________

Date of last exposure to the case: ________________________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: __________ __________ __________

Hx of **Prior TB**: ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment**: ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: __________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: __________

Date Tx Started: __________

Date Tx Stopped: __________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

Virginia Department of Health Division of Tuberculosis (TB) and Newcomer Health ~ TB Contact Investigation Final Summary Form (FINAL TB 502)

Index Case ID# ____________________ **District** ____________________ **Nurse Case Manager Name** ____________________ **Nurse Case Manager Phone #** ________________

Date Case/Presumptive Reported to Local Health Dept. ______________________ **Date Contact Investigation Initiated** ______________________

Type of Investigation: ☐ Contact ☐ Source Case **Type of Case** ☐ Pulmonary Smear Pos. ☐ Pulmonary Culture Pos. ☐ Pulmonary Smear Neg. ☐ Extrapulmonary ☐ Clinical ☐ GeneXpert Pos.

Infectious Period

Start Date: __________ End Date: __________

Contact Last Name: ____________________ **First Name**: ____________________

DOB: ______________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ________________ ☐ Hispanic ☐ Not Hispanic

Address: ____

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________________

Date of last exposure to the case: ________________________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: _________ _________ _________

Hx of **Prior TB** ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: __________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: __________

Date Tx Started: __________

Date Tx Stopped: __________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

---

Contact Last Name: ____________________ **First Name**: ____________________

DOB: ______________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ________________ ☐ Hispanic ☐ Not Hispanic

Address: ____

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________________

Date of last exposure to the case: ________________________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: _________ _________ _________

Hx of **Prior TB** ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: __________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: __________

Date Tx Started: __________

Date Tx Stopped: __________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

---

Contact Last Name: ____________________ **First Name**: ____________________

DOB: ______________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ________________ ☐ Hispanic ☐ Not Hispanic

Address: ____

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________________

Date of last exposure to the case: ________________________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: _________ _________ _________

Hx of **Prior TB** ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: __________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: __________

Date Tx Started: __________

Date Tx Stopped: __________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

Virginia Department of Health Division of Tuberculosis (TB) and Newcomer Health ~ TB Contact Investigation Final Summary Form (FINAL TB 502)

Index Case ID# ____________ **District** ____________ **Nurse Case Manager Name** ____________ **Nurse Case Manager Phone #** ____________

Date Case/Presumptive Reported to Local Health Dept. ____________ **Date Contact Investigation Initiated** ____________

Type of Investigation: ☐ Contact ☐ Source Case **Type of Case** ☐ Pulmonary Smear Pos. ☐ Pulmonary Culture Pos. ☐ Pulmonary Smear Neg. ☐ Extrapulmonary ☐ Clinical ☐ GeneXpert Pos.

Infectious Period

Start Date: ____________ End Date: ____________

Contact Last Name: ____________ **First Name**: ____________

DOB: ____________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ____________ ☐ Hispanic ☐ Not Hispanic

Address: ____________

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________

Date of last exposure to the case: ____________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: ____________ ____________ ____________

Hx of **Prior TB** ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1:
Date Tested: ____________
Result: _____ mm if TST
☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2:
Date Tested: ____________
Result: _____ mm if TST
☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: ____________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: ____________

Date Tx Started: ____________

Date Tx Stopped: ____________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

---

Contact Last Name: ____________ **First Name**: ____________

DOB: ____________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ____________ ☐ Hispanic ☐ Not Hispanic

Address: ____________

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________

Date of last exposure to the case: ____________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: ____________ ____________ ____________

Hx of **Prior TB** ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1:
Date Tested: ____________
Result: _____ mm if TST
☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2:
Date Tested: ____________
Result: _____ mm if TST
☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: ____________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: ____________

Date Tx Started: ____________

Date Tx Stopped: ____________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

---

Contact Last Name: ____________ **First Name**: ____________

DOB: ____________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ____________ ☐ Hispanic ☐ Not Hispanic

Address: ____________

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________

Date of last exposure to the case: ____________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: ____________ ____________ ____________

Hx of **Prior TB** ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1:
Date Tested: ____________
Result: _____ mm if TST
☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2:
Date Tested: ____________
Result: _____ mm if TST
☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: ____________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: ____________

Date Tx Started: ____________

Date Tx Stopped: ____________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

Virginia Department of Health Division of Tuberculosis (TB) and Newcomer Health ~ TB Contact Investigation Final Summary Form (FINAL TB 502)

Index Case ID# ____________ **District** ____________ **Nurse Case Manager Name** ____________ **Nurse Case Manager Phone #** ____________

Date Case/Presumptive Reported to Local Health Dept. ____________ **Date Contact Investigation Initiated** ____________

Type of Investigation: ☐ Contact ☐ Source Case **Type of Case** ☐ Pulmonary Smear Pos. ☐ Pulmonary Culture Pos. ☐ Pulmonary Smear Neg. ☐ Extrapulmonary ☐ Clinical ☐ GeneXpert Pos.

Infectious Period

Start Date: ________ End Date: ________

Contact Last Name: ____________ **First Name**: ____________

DOB: ____________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ____________ ☐ Hispanic ☐ Not Hispanic

Address: ____________

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________

Date of last exposure to the case: ____________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: ________ ________ ________

Hx of **Prior TB** ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1: Date Tested: ________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2: Date Tested: ________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: ________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: ________

Date Tx Started: ________

Date Tx Stopped: ________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

---

Contact Last Name: ____________ **First Name**: ____________

DOB: ____________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ____________ ☐ Hispanic ☐ Not Hispanic

Address: ____________

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________

Date of last exposure to the case: ____________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: ________ ________ ________

Hx of **Prior TB** ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1: Date Tested: ________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2: Date Tested: ________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: ________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: ________

Date Tx Started: ________

Date Tx Stopped: ________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

---

Contact Last Name: ____________ **First Name**: ____________

DOB: ____________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ____________ ☐ Hispanic ☐ Not Hispanic

Address: ____________

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________

Date of last exposure to the case: ____________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: ________ ________ ________

Hx of **Prior TB** ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1: Date Tested: ________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2: Date Tested: ________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: ________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: ________

Date Tx Started: ________

Date Tx Stopped: ________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

Virginia Department of Health Division of Tuberculosis (TB) and Newcomer Health ~ TB Contact Investigation Final Summary Form (FINAL TB 502)

Index Case ID# ________________ **District** ________________ **Nurse Case Manager Name** ________________ **Nurse Case Manager Phone #** ________________

Date Case/Presumptive Reported to Local Health Dept. ____________________ **Date Contact Investigation Initiated** ____________________

Type of Investigation: ☐ Contact ☐ Source Case **Type of Case** ☐ Pulmonary Smear Pos. ☐ Pulmonary Culture Pos. ☐ Pulmonary Smear Neg. ☐ Extrapulmonary ☐ Clinical ☐ GeneXpert Pos.

Infectious Period

Start Date: __________ End Date: __________

Contact	Priority / Symptoms	Hx of Prior TB / Prior Treatment	LTBI Test Used	CXR	Treatment
Contact Last Name: ________ **First Name**: ________ **DOB**: ________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other **Sex**: ________ ☐ Hispanic ☐ Not Hispanic **Address**: ________ **Contact Relationship to Case**: ☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ________ **Date of last exposure to the case**: ________	**Priority**: ☐ High ☐ Medium ☐ Low **Symptoms**: ☐ Yes ☐ No If yes, list: ________ ________ ________	Hx of **Prior TB** ☐ LTBI ☐ TB Disease Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown	**LTBI Test Used:** ☐ TST ☐ IGRA **Round 1:** Date Tested: ________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline **Round 2:** Date Tested: ________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline	**CXR Date:** ________ **CXR Result:** ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary	**TB Case?** ☐ Yes ☐ No **LTBI Tx Recommended?** ☐ Yes ☐ No If yes: **Tx Type**: ________ **Date Tx Started**: ________ **Date Tx Stopped**: ________ **Tx Stop Reason**: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision
Contact Last Name: ________ **First Name**: ________ **DOB**: ________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other **Sex**: ________ ☐ Hispanic ☐ Not Hispanic **Address**: ________ **Contact Relationship to Case**: ☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ________ **Date of last exposure to the case**: ________	**Priority**: ☐ High ☐ Medium ☐ Low **Symptoms**: ☐ Yes ☐ No If yes, list: ________ ________ ________	Hx of **Prior TB** ☐ LTBI ☐ TB Disease Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown	**LTBI Test Used:** ☐ TST ☐ IGRA **Round 1:** Date Tested: ________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline **Round 2:** Date Tested: ________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline	**CXR Date:** ________ **CXR Result:** ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary	**TB Case?** ☐ Yes ☐ No **LTBI Tx Recommended?** ☐ Yes ☐ No If yes: **Tx Type**: ________ **Date Tx Started**: ________ **Date Tx Stopped**: ________ **Tx Stop Reason**: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision
Contact Last Name: ________ **First Name**: ________ **DOB**: ________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other **Sex**: ________ ☐ Hispanic ☐ Not Hispanic **Address**: ________ **Contact Relationship to Case**: ☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ________ **Date of last exposure to the case**: ________	**Priority**: ☐ High ☐ Medium ☐ Low **Symptoms**: ☐ Yes ☐ No If yes, list: ________ ________ ________	Hx of **Prior TB** ☐ LTBI ☐ TB Disease Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown	**LTBI Test Used:** ☐ TST ☐ IGRA **Round 1:** Date Tested: ________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline **Round 2:** Date Tested: ________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline	**CXR Date:** ________ **CXR Result:** ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary	**TB Case?** ☐ Yes ☐ No **LTBI Tx Recommended?** ☐ Yes ☐ No If yes: **Tx Type**: ________ **Date Tx Started**: ________ **Date Tx Stopped**: ________ **Tx Stop Reason**: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

Virginia Department of Health Division of Tuberculosis (TB) and Newcomer Health ~ TB Contact Investigation Final Summary Form (FINAL TB 502)

Index Case ID# ___________________ **District** ____________________ **Nurse Case Manager Name** _____________________ **Nurse Case Manager Phone #** ________________

Date Case/Presumptive Reported to Local Health Dept. _______________________ **Date Contact Investigation Initiated** ______________________

Type of Investigation: ☐ Contact ☐ Source Case **Type of Case** ☐ Pulmonary Smear Pos. ☐ Pulmonary Culture Pos. ☐ Pulmonary Smear Neg. ☐ Extrapulmonary ☐ Clinical ☐ GeneXpert Pos.

Infectious Period	
Start Date: __________	End Date: __________

Contact Last Name: ______________________ **First Name**: _______________________

DOB: ______________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ________________ ☐ Hispanic ☐ Not Hispanic

Address: ____

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________________

Date of last exposure to the case: _________________________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: _________ _________ _________

Hx of **Prior TB** ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: __________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: __________

Date Tx Started: __________

Date Tx Stopped: __________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

---

Contact Last Name: ______________________ **First Name**: _______________________

DOB: ______________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ________________ ☐ Hispanic ☐ Not Hispanic

Address: ____

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________________

Date of last exposure to the case: _________________________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: _________ _________ _________

Hx of **Prior TB** ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: __________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: __________

Date Tx Started: __________

Date Tx Stopped: __________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

---

Contact Last Name: ______________________ **First Name**: _______________________

DOB: ______________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ________________ ☐ Hispanic ☐ Not Hispanic

Address: ____

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________________

Date of last exposure to the case: _________________________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: _________ _________ _________

Hx of **Prior TB** ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: __________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: __________

Date Tx Started: __________

Date Tx Stopped: __________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

Virginia Department of Health Division of Tuberculosis (TB) and Newcomer Health ~ TB Contact Investigation Final Summary Form (FINAL TB 502)

Index Case ID# ____________________ **District** ____________________ **Nurse Case Manager Name** ____________________ **Nurse Case Manager Phone #** ________________

Date Case/Presumptive Reported to Local Health Dept. ______________________ **Date Contact Investigation Initiated** ______________________

Type of Investigation: ☐ Contact ☐ Source Case **Type of Case** ☐ Pulmonary Smear Pos. ☐ Pulmonary Culture Pos. ☐ Pulmonary Smear Neg. ☐ Extrapulmonary ☐ Clinical ☐ GeneXpert Pos.

Infectious Period

Start Date: __________ End Date: __________

Contact Last Name: ____________________ **First Name**: ____________________

DOB: ______________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ________________ ☐ Hispanic ☐ Not Hispanic

Address: ____

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________________

Date of last exposure to the case: ________________________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: _________ _________ _________

Hx of **Prior TB** ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: __________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: __________

Date Tx Started: __________

Date Tx Stopped: __________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

---

Contact Last Name: ____________________ **First Name**: ____________________

DOB: ______________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ________________ ☐ Hispanic ☐ Not Hispanic

Address: ____

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________________

Date of last exposure to the case: ________________________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: _________ _________ _________

Hx of **Prior TB** ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: __________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: __________

Date Tx Started: __________

Date Tx Stopped: __________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision

---

Contact Last Name: ____________________ **First Name**: ____________________

DOB: ______________ **Race/Ethnicity**: ☐ American Indian/AK Native ☐ Asian ☐ Black ☐ White ☐ Native HI/Pacific Islander ☐ Other

Sex: ________________ ☐ Hispanic ☐ Not Hispanic

Address: ____

____

Contact Relationship to Case:

☐ Household ☐ School ☐ Workplace ☐ Place of Worship ☐ Hospital ☐ Medical Office ☐ Social Setting ☐ Correctional Facility ☐ Long Term Care Facility ☐ Shelter ☐ Other (if other please specify): ____________________

Date of last exposure to the case: ________________________

Priority: ☐ High ☐ Medium ☐ Low

Symptoms: ☐ Yes ☐ No

If yes, list: _________ _________ _________

Hx of **Prior TB** ☐ LTBI ☐ TB Disease

Hx of **Prior Treatment** ☐ Completed Tx ☐ Partially treated ☐ Never treated ☐ Unknown

LTBI Test Used: ☐ TST ☐ IGRA

Round 1: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

Round 2: Date Tested: __________ Result: _____ mm if TST ☐ Pos. ☐ Neg. ☐ Indeterminate/ Borderline

CXR Date: __________

CXR Result: ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non. Cavitary

TB Case? ☐ Yes ☐ No

LTBI Tx Recommended? ☐ Yes ☐ No

If yes: **Tx Type**: __________

Date Tx Started: __________

Date Tx Stopped: __________

Tx Stop Reason: ☐ Completed Therapy ☐ Death ☐ Moved (follow-up unknown) ☐ Active TB developed ☐ Adverse effects of medication ☐ Chose to Stop ☐ Lost to follow-up ☐ Provider decision