STATE OF CT TUBERCULOSIS CONTROL PROGRAM – SOURCE CASE INVESTIGATION WORKSHEET (TB-5 SOURCE)

410 Capitol Avenue, MS #11TUB, P.O. Box 340308, Hartford, CT 06134-0308 Voice: (860) 509-7722 Fax:: (860) 509-7743

CLIENT INFORMATION:
NAME (LAST,FIRST, MI)_____ DOB:_____
ADDRESS:_____ PHONE:_____

DATE REPORT SENT:
_____/_____/_____

SENT TO:
_____

INTERVIEWER:
_____
FACILITY:
_____
PERSON COMPLETING REPORT: _____
PHONE:_____

CONTACT INFORMATION:	TST/QFT	CXR	TREATMENT DATE STARTED:	PROVIDER:
FIRST NAME:_____ LAST NAME:_____ ADDRESS:_____ _____ PHONE:_____ DOB: _____/_____/_____ GENDER: CHOOSE ONE RACE:_____ ETHNICITY:_____	☐ TST ☐ QFT DATE: _____/_____/_____ TST INDURATION: _____MM QFT RESULT: ☐ POSITIVE ☐ NEGATIVE ☐ INDETERMINATE	DATE:_____/_____/_____ ☐ NORMAL ☐ ABNORMAL -CONSISTENT WITH INACTIVE TB ☐ ABNORMAL-CONSISTENT WITH TB DISEASE HIV TEST DATE: _____/_____/_____ RESULTS: ☐ POS ☐ NEG ☐ INDETERMINATE	_____/_____/_____ REGIMEN: ☐ INH ☐ RIF ☐ PZA ☐ EMB ☐ OTHER_____ NO RX: REASON:_____	NAME:_____ ADDRESS:_____ _____ PHONE:_____
CONTACT INFORMATION: FIRST NAME:_____ LAST NAME:_____ ADDRESS:_____ _____ PHONE:_____ DOB: _____/_____/_____ GENDER:_____ RACE:_____ ETHNICITY:_____	TST/QFT ☐ TST ☐ QFT DATE: _____/_____/_____ TST INDURATION: _____MM QFT RESULT: ☐ POSITIVE ☐ NEGATIVE ☐ INDETERMINATE	CXR DATE:_____/_____/_____ ☐ NORMAL ☐ ABNORMAL -CONSISTENT WITH INACTIVE TB ☐ ABNORMAL-CONSISTENT WITH TB DISEASE HIV TEST DATE: _____/_____/_____ RESULTS: ☐ POS ☐ NEG ☐ INDETERMINATE	TREATMENT DATE STARTED: _____/_____/_____ REGIMEN: ☐ INH ☐ RIF ☐ PZA ☐ EMB ☐ OTHER_____ NO RX: REASON:_____	PROVIDER: NAME:_____ ADDRESS:_____ _____ PHONE:_____
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STATE OF CT TUBERCULOSIS CONTROL PROGRAM – SOURCE CASE INVESTIGATION WORKSHEET (TB-5 SOURCE)- PAGE 2

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