



# CureTB Contact/Source Investigation (CI/SI) Notification

OMB APPROVED  
CONTROL NO 0920-1186  
EXP DATE: 01/31/2021

Division of Global Migration and Quarantine | E-mail: curetb@cdc.gov | Telephone: 619-542-4013 |  
Fax For California: 619-692-8020 | Fax For other areas: 404-471-8905 | Web address: [www.cdc.gov/usmexicohealth/curetb.html](http://www.cdc.gov/usmexicohealth/curetb.html)

<sup>1</sup>Referring Jurisdiction: \_\_\_\_\_ <sup>1</sup>Date sent: \_\_\_\_\_  
City County State

<sup>1</sup>Contact person: \_\_\_\_\_ <sup>1</sup>Telephone: \_\_\_\_\_ Ext: \_\_\_\_\_ Fax: \_\_\_\_\_

Referring Agency: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Index Patient Information for:  Contact Investigation  Source Investigation

**A. Index Patient Information**

<sup>1</sup>Name: \_\_\_\_\_ Sex:  M  F  
Paternal Maternal First Middle

Alias: \_\_\_\_\_ DOB or Age: \_\_\_\_\_ Parent's Name (if child for SI): \_\_\_\_\_

Number Street Apt City  
County State Zip code Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Check if patient/parent not currently home. Current location: \_\_\_\_\_ Tel: \_\_\_\_\_

Contact person Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Relationship: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

**Clinical Information:**

Site(s) of disease: Pulmonary Meningeal Disseminated Other(s), specify: \_\_\_\_\_

<sup>2</sup> Date of collection	<sup>2</sup> Specimen type	<sup>2</sup> Smear	Culture	Susceptibility			Treatment:	Start Date:
				Drug	Sens	Res		
				INH			Comments:	
				RIF				
				EMB				
				PZA				

HIV Diabetes No Symptoms Symptoms,specify: \_\_\_\_\_

**B. Contacts/Possible Sources**

**Primary Address of Exposure**

Address: \_\_\_\_\_  
Country: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name	DOB or Age	Relationship to index Patient	Date Last Exposure	Phone # (H=Home; C=Cell)	Risk Factors			Sx	On Tx
					≤ 5 y/o	HIV/AIDS	Immunosuppression		

**Other Address of Exposure**

Address: \_\_\_\_\_  
Country: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name	DOB or Age	Relationship to index Patient	Date Last Exposure	Phone # (H=Home; C=Cell)	Risk Factors			Sx	On Tx
					≤ 5 y/o	HIV/AIDS	Immunosuppression		

Comments: \_\_\_\_\_

1. Fields required to initiate the referral process  
 2. Please send imaging and laboratory reports as attachments  
 3. Please attach additional information, as needed.

Public reporting burden of this collection of information is estimated to average 30 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 D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-004