CureTB Contact/Source Investigation (CI/SI) Notification

Reset Form

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

[1]Referring Jurisdiction: _____ (City / County / State) [1]Date sent: _____

[1]Contact person: _____ [1]Telephone: _____ Ext: _____ Fax: _____

Referring Agency: _____ E-Mail Address: _____

Index Patient Information for: ☐ Contact Investigation ☐ Source Investigation

A. Index Patient Information

[1]Name: _____ (Paternal / Maternal / First / Middle) Sex: ☐ M ☐ F

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: _____

[2]Date of collection	[2]Specimen type	[2]Smear	Culture	Susceptibility		
				Drug	Sens	Res
				INH	☐	☐
				RIF	☐	☐
				EMB	☐	☐
				PZA	☐	☐

Treatment: **Start Date:**

Comments:

☐ 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.