

**PLEASE PRINT OR TYPE ALL INFORMATION!**

<b>NJDOH USE ONLY:</b>	Date Counted: _____	Final Dx (Check one):	<input type="checkbox"/> + Sputum Smear	<input type="checkbox"/> Neg. Sputum Smear/+ Sputum Culture
			<input type="checkbox"/> Pulm-Other-Cul	<input type="checkbox"/> Pulm-Clinical
				<input type="checkbox"/> Extra-Pulm

**New Jersey Department of Health  
TB Program  
PO Box 363, Trenton, NJ 08625-0363**

**RECORD OF CONTACT INTERVIEW**

Initial       Interim       Final  
 No Contacts Identified     Interview Not Done

TB-70 #
Date Reported

Name: Last	First	MI	Street Address		
City	County	Zip Code	Date of Birth	Telephone Number	
Name of Employer/School/Congregate Setting			Address		
Telephone Number of Employer/School/Congregate Setting			Occupation		
Date of Interview	Date of Reinterview	Infectious Period: From: _____ To: _____		Reason for Interview <input type="checkbox"/> Case <input type="checkbox"/> Suspect <input type="checkbox"/> Child <5 Years Old	

CONTACT INFORMATION						EXAMINATION RESULTS					Remarks
Last Name, First Name Address/Telephone Number	Nature of Contact (Codes 1-8)	DOB and/or Age	Sex	For- eign Born	Last Exposure Date	Date Done	Date Done	X-Ray Date	Therapy Date	Completed Rx Date or Incomplete Code A-G	
						Results	Results	Results	Meds (K-P)		
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm	<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm	_____	_____		
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm	<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm	_____	_____		
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm	<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm	_____	_____		
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm	<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm	_____	_____		
Name and Title of Interviewer						Agency Name					
Signature			Date Submitted			Agency Telephone Number			Reviewed by NJDOH (Initials and Date)		

# RECORD OF CONTACT INTERVIEW, Continued

TB-70 #

Name: Last	First	MI	County
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CONTACT INFORMATION						EXAMINATION RESULTS					Remarks
Last Name, First Name Address/Telephone Number	Nature of Contact (Codes 1-8)	DOB and/or Age	Sex	For- eign Born	Last Exposure Date	Date Done	Date Done	X-Ray Date	Therapy Date	Completed Rx Date or Incomplete Code A-G	
						Results	Results	Results	Meds (K-P)		
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm	<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm				
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm	<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm				
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm	<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm				
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm	<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm				
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm	<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm				
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm	<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm				
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm	<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm				
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm	<input type="checkbox"/> QFT- <input type="checkbox"/> QFT+ mm				

**NATURE OF CONTACT:** 1-Household 2-Worksite 3-School 4-Jail/Prison 5-Health Care Facility 6-Social 7-Shelter 8-Other  
**MEDS:** K-INH L-RIF M-INH or RIF Intermittent N-Special Regimen (MDR) O-Other LTBI Rx P-Rx for TB Case/Suspect  
**RX INCOMPLETE:** A-Death B-Moved, Records Referred C-Active TB D-Adverse Effects E-Refused F-Lost G-Provider Decision