PLEASE PRINT OR TYPE ALL INFORMATION!

NJDOH USE ONLY:	Date Counted: _____	Final Dx (Check one): ☐ + Sputum Smear ☐ Neg. Sputum Smear/+ Sputum Culture ☐ Pulm-Other-Cul ☐ Pulm-Clinical ☐ 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 ☐ Case ☐ Suspect ☐ Child <5 Years Old

CONTACT INFORMATION / EXAMINATION RESULTS

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 / Results	Date Done / Results	X-Ray Date / Results	Therapy Date / Meds (K-P)	Completed Rx Date or Incomplete Code A-G	Remarks
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ __mm	☐QFT- ☐QFT+ __mm	_____	_____		
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ __mm	☐QFT- ☐QFT+ __mm	_____	_____		
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ __mm	☐QFT- ☐QFT+ __mm	_____	_____		
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ __mm	☐QFT- ☐QFT+ __mm	_____	_____		

Name and Title of Interviewer	Agency Name

Signature	Date Submitted	Agency Telephone Number	Reviewed by NJDOH (Initials and Date)

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

TB-70 #

Name: Last	First	MI	County

CONTACT INFORMATION						EXAMINATION RESULTS					
Last Name, First Name Address/Telephone Number	**Nature of Contact (Codes 1-8)**	**DOB and/or Age**	**Sex**	**Foreign Born**	**Last Exposure Date**	**Date Done** / Results	**Date Done** / Results	**X-Ray Date** / Results	**Therapy Date** / Meds (K-P)	**Completed Rx Date or Incomplete Code A-G**	**Remarks**
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ ____ mm	☐QFT- ☐QFT+ ____ mm	_____	_____		
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ ____ mm	☐QFT- ☐QFT+ ____ mm	_____	_____		
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ ____ mm	☐QFT- ☐QFT+ ____ mm	_____	_____		
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ ____ mm	☐QFT- ☐QFT+ ____ mm	_____	_____		
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ ____ mm	☐QFT- ☐QFT+ ____ mm	_____	_____		
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ ____ mm	☐QFT- ☐QFT+ ____ mm	_____	_____		
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ ____ mm	☐QFT- ☐QFT+ ____ mm	_____	_____		
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ ____ mm	☐QFT- ☐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

TB-41
AUG 13

TB-70 #

Name: Last	First	MI	County

CONTACT INFORMATION						EXAMINATION RESULTS					
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** Results	**Date Done** Results	**X-Ray Date** Results	**Therapy Date** Meds (K-P)	**Completed Rx Date or Incomplete Code A-G**	**Remarks**
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ mm	☐QFT- ☐QFT+ mm	_____	_____		
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ mm	☐QFT- ☐QFT+ mm	_____	_____		
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ mm	☐QFT- ☐QFT+ mm	_____	_____		
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ mm	☐QFT- ☐QFT+ mm	_____	_____		
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ mm	☐QFT- ☐QFT+ mm	_____	_____		
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ mm	☐QFT- ☐QFT+ mm	_____	_____		
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ mm	☐QFT- ☐QFT+ mm	_____	_____		
			☐M ☐F	☐Y ☐N		☐QFT- ☐QFT+ mm	☐QFT- ☐QFT+ mm	_____	_____		

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