



TB Contact/Source case investigation (Form: 3)

<p>Name: _____ Address: _____ _____ _____ Tel: _____ GP _____ Hospital No _____</p>	<p>DOB: _____ Sex: M <input type="checkbox"/> F <input type="checkbox"/></p> <p>Relationship to index: _____ Date last contact: _____ Contact risk code _____ Date referred: _____ Date screened: _____</p>	<p>Outcome: _____ _____ _____ _____</p>
<p>Name: _____ Address: _____ _____ _____ Tel: _____ GP _____ Hospital No _____</p>	<p>DOB: _____ Sex: M <input type="checkbox"/> F <input type="checkbox"/></p> <p>Relationship to index: _____ Date last contact: _____ Contact risk code _____ Date referred: _____ Date screened: _____</p>	<p>Outcome: _____ _____ _____ _____</p>
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<p>Name: _____ Address: _____ _____ _____ Tel: _____ GP _____ Hospital No _____</p>	<p>DOB: _____ Sex: M <input type="checkbox"/> F <input type="checkbox"/></p> <p>Relationship to index: _____ Date last contact: _____ Contact risk code _____ Date referred: _____ Date screened: _____</p>	<p>Outcome: _____ _____ _____ _____</p>

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<b>Comments:</b>		<b>Audit</b>	
** Initiate FORM 1 for all contacts   		<b>Total no. of contacts identified:</b> _____ <b>I</b> No. contacts screened _____ <b>J</b> No. non-attendees _____ <b>K</b> No. contacts Mantoux / IGT +ve _____ <b>L</b> No. contacts commenced on preventive Rx _____ <b>M</b> No. contacts commenced on TB Rx _____ <b>N</b> All high risk contacts seen within 2 weeks Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Initial assessment by (Name):</b> _____		<b>Date:</b> _____	
<b>Signature:</b> _____		<b>Designation:</b> _____	

<b>Form 3: Continuation Sheet</b> . Index case name.		Hospital No.

Source:  
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