

FOLLOW-UP CONTACT ASSESSMENT – TUBERCULOSIS CONTROL

Please fax completed form to: Vancouver TB Clinic – 604-707-2690 / New West: 604-707-2694

Index Case:	PHN:	TB #:	DOB: (YYYY/ MM/DD)
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Name:	Address:	DOB: (YYYY/ MM/DD)	PHN:	(M/F)	ABG: *	Contact Type: (1,2,3)	TST #1		TST #2	
							Date Read: (YYYY/ MM/DD)	Size: (mm)	Date Read: (YYYY/ MM/DD)	Size: (mm)

*** ABORIGINAL STATUS:**
 1: Registered On-Reserve 2: Registered Off-Reserve 3: Non-Registered On-Reserve 4: Non-Registered Off-Reserve 5: Métis 6: Inuit 7: Non-Status

Regardless of TST, if symptoms - send sputums x 3 + chest x-ray

Send all completed 939s on all contacts and if TST+ send for CXR