

TUBERCULOSIS CONTACT LIST

2nd Floor, South Tower 10030 107 Street Edmonton AB T5J 3E4 Phone: 780-735-1464 Fax: 780-735-1195

Section should	be read by, c	or to the client.																		
Information an Legislation	manageme	Information on this form is collected under the authority of section 20(b) of the Health Information Act (as per section 27(1)(a) and 27(2)) for the purposes of providing a health service, planning and resource allocation, health system management, public health surveillance and health policy development. Questions about the use and collection of this information can be directed to the contact information provided at the top of this form.																		
CONTACT EV	/ENT																			
				Ctart Data) at a	C F		-4:										
Exposure Cate				Start Date		End D	ate	Case Eve	Event/Location Event/Location											
(Please see rev		categories)																		
SOURCE CA																				
TB Number	Fam	nily Name	Firs	t Name	PHN	1	DIAND Nu	mber	Health	Area/H	lealth Cent	tre	Branch	E	Birth Date	Treatment	Started Date I	-lospital	Admission Date	Attending Physician
Home Address	1		Ci	ty		Prov.	Postal Code	Phone			Diagnosis			AFB Res	sults		Intervi	ewer	Position	Date
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CONTACTS								,				Conta	act Relation				l			
CONTACTO									$\overline{}$						Tube	culin Tests				
Contact Name		ame		Birth Date					ne	Last Contact I	Date		ousehold						Comme CXR/Sputum/Syn	
TB # or PHN			Sex	YYYY MM DD		Addre	:SS					Yes	No	MM	Date Given	MM	Date Given	BCG Date		



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Information and Privacy Legislation Information on this management, pub Questions about the			ent, publi	c health surveilla	nce a	nd health p	olicy develop	ment.							7(2)) for the p	ourposes of	providing a heal	th service, plannin	g and resource allocatio	n, health system
CONTACT E	VENT																			
				Start Date		End Da	End Date Case Event/Location													
(Please see rev	erse side	e for categories)																		
SOURCE CA	SE			•			· ·													
		Fir	First Name PHN		N	DIAND Num		r Health Area		ealth Centre	Branch		Birth Date		Treatment Started Date H		Hospital	Admission Date	Attending Physician	
Home Address	I		С	City		Prov. I	Postal Code	Phone	;	Diagnosis		1	AFB F	AFB Results			Interv	iewer	Position	Date
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CONTACTS						<u> </u>				Į.	Cor	ntact Relation					'		1	•
Contact		Name								Las	st Household		Tube			culin Tests			Comme	nts
TB # or PHN		Name	Sex	Birth Date YYYY MM DD		Addres	Address		one	Contact	Date Yes	No	MM		Date Given	MM	Date Given	BCG Date	CXR/Sputum/Syn	nptom Inquiry

EXPC	SURE CATEGORY
Please	e select the exposure category these contacts belong to and enter the code in Exposure Category field on previous page.
01	Acute Care Facility
02	Commercial Setting
03	Continuing Care Facility
04	Correctional Facility
05	Other
06	Rehabilitation Facility
07	School
08	Shelter/Hostel
09	Social Event
10	Travel
11	Workplace