



# Corrections Contact Investigation Evaluation Summary

Facility \_\_\_\_\_

Date: \_\_\_\_\_

## INDEX CASE

### MEDICAL:

Initials of Client: \_\_\_\_\_ DOB: \_\_\_\_\_ Race/Sex: \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_  
(Date of incarceration)

\_\_\_\_\_  
(Date of isolation)

\_\_\_\_\_  
(1<sup>st</sup> date of symptoms)

TST: \_\_\_\_\_ mm  
(results)

Date: \_\_\_\_\_  
(of reading)

CXR: \_\_\_\_\_  
(Date)

CXR Results: \_\_\_\_\_

Smears: 1<sup>st</sup> \_\_\_\_\_ / \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ / \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_ / \_\_\_\_\_  
(AFBx3) (Result) (Date) (Result) (Date) (Result) (Date)

MTD: \_\_\_\_\_ / \_\_\_\_\_ HIV Status: Positive Neg. Not Tested  
(Result) (Date)

Culture: 1<sup>st</sup> \_\_\_\_\_ / \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ / \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_ / \_\_\_\_\_  
(Result) (Date) (Result) (Date) (Result) (Date)

Sensitivities: \_\_\_\_\_

List TB Meds: \_\_\_\_\_ Date: \_\_\_\_\_  
(started on meds)

### Signature/Printed Name/Title of person completing this section:

\_\_\_\_\_  
Signature Printed Name Title Phone Number

### NARRATIVE SUMMARY:

List Arrest Record since beginning of S/S: \_\_\_\_\_  
(How Many Arrests since 1<sup>st</sup> date of S/S)

\_\_\_\_\_  
(Date of Incarceration/Date of Release, other release dates if after initial one)

List any sick calls, clinic visits, etc.: \_\_\_\_\_

Name: \_\_\_\_\_

ID#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Movement:**

Client Name: \_\_\_\_\_

List how many cells transferred to while incarcerated: \_\_\_\_\_

\_\_\_\_\_  
(Include how many persons in cell, e.g., transferred to 18-man cell with 22 in cell)

List any other pertinent information available: \_\_\_\_\_

**Signature/Printed Name/Title of person completing this section:**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature Printed Name Title Phone No.

**CONTACT INVESTIGATION FOLLOW-UP:**

Total # of Contacts Identified: \_\_\_\_\_  
Inmates Corrections Medical Staff

# Of Contacts Tested: \_\_\_\_\_

# Previous Positive: \_\_\_\_\_

# Positive: \_\_\_\_\_

# Re-Test: (12-week) \_\_\_\_\_

# Positive: \_\_\_\_\_

# Chest x-rays \_\_\_\_\_

# Suspects \_\_\_\_\_

# Completed Evaluations \_\_\_\_\_

# LTBI Treatment initiated \_\_\_\_\_

# LTBI Completed \_\_\_\_\_

# LTBI Not Completed \_\_\_\_\_

**Those not completing treatment:**

# Transferred to Other Facility. \_\_\_\_\_

# Released to Community \_\_\_\_\_

# On Work Release \_\_\_\_\_

# Active TB Developed \_\_\_\_\_

# Adverse Effect of Meds \_\_\_\_\_

# Provider Decision to D/C \_\_\_\_\_

If released, Date of Release: \_\_\_\_\_ To: \_\_\_\_\_  
(Facility/Community)

Name/Title of Contact Notified: \_\_\_\_\_

**Signature/Printed Name/Title of person completing this section:**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature Printed Name Title Phone Number

Please return this form to the TB Control Section by a secure, confidential method.  
Fax: 850-921-9906 or Mail: 4052 Bald Cypress Way, Bin A-20, Tallahassee, Florida 32399