

Form 2D: Avian Influenza Contact Tracing Form

1. Last Name: _____ First Name: _____ MI: _____ Suffix: _____ Alias: _____					2. Street Address: _____ Apt #: _____																
3. City: _____ State: <input type="text"/>		4. Zip: <input type="text"/>		5. DOB: <input type="text"/>		6. Age (Yrs): <input type="text"/>		7. Ethnicity: <input type="text"/>		8. Race - Mark all that apply: <input type="text"/>		9. Sex: <input type="text"/>		20. Phone Number - Home: <input type="text"/>							
10. Height: _____	11. Size/Build: _____	12. Hair: _____	13. Complexion: _____	14. Pregnant?: <input type="text"/>	15. Primary Language Spoken: _____	16. English Spoken: <input type="text"/>	17. Name of Employer/School: _____					21. Phone Number - Cell: <input type="text"/>									
24. Exposure Dates:			25. Reported Case Number: _____			26. Date Interview of Reported Case: <input type="text"/>			18. Address of Employer/School: _____			19. Work Hours: _____			22. Phone Number - Work: <input type="text"/>						
Date of First Exposure: <input type="text"/>			State: _____												23. Phone Number - Other: <input type="text"/>						
Date of Last Exposure: <input type="text"/>			29. Location, Epi Notes, and Other Relevant Information: _____																		
27. Contact Type (Mark One)		28. Priority Code *																			
Primary Contact																					
OOJ Primary Contact																					
Case Contact Priority Codes * 1 = Highest Priority - Case household contacts: All immediate family members; others spending > 3 hours in the household since case's onset of symptoms. 2 = Non household contacts with contact <3 feet with an infectious case for >= 3 hours. 3 = Non household contacts with contact <3 feet with an infectious case for < 3 hours. 4 = Non household contacts with contact >=3 feet with an infectious case for >= 3 hours. 5 = Non household contacts with contact >=3 feet with an infectious case for < 3 hours.													30. Date Form 2D Initiated: <input type="text"/>			31. Initiated By: _____			38. Disposition (Select One) 1. Located <input type="checkbox"/> 1A Started a Post-Exposure Prophylaxis Symptoms Not Present <input type="checkbox"/> 1B Referred for Clinical Assessment, Symptoms Present <input type="checkbox"/> 1C Already Hospitalized as Suspected Case, Symptoms Present <input type="checkbox"/> 1D Isolated, Not Prophylaxed, Asymptomatic 2. Not Located <input type="checkbox"/> 2A Unable to Locate <input type="checkbox"/> 2B Moved From Jurisdiction, To: _____ 3. Deceased <input type="checkbox"/> 3A Disease Suspected <input type="checkbox"/> 3B Unrelated to Disease 4. <input type="checkbox"/> 4 Other: _____ ³⁹		
													32. Date of Contact Notification: <input type="text"/>			33. Notified By: _____					
													34. Disposition Date: <input type="text"/>			35. Dispo'ed By: _____					
													36. Follow-up Assignment Date: <input type="text"/>			37. Follow-up By: _____					
																40. Reviewed By: _____			41. Comments: _____		
													39. Case ID: _____ State: _____								