

**General Land Contact Investigation Outcome Reporting Form**  
**FAX completed form to the CDC at 404.718.2158; For questions, call 404.639.7147**

1. TRAVEL INFORMATION					
CDC/QARS ID#	Arrival date	Departure city, state, <b>country</b>	Arrival city, state, <b>country</b>	<b>Port of Entry or Border Patrol Sector:</b>	<input type="checkbox"/> Train <input type="checkbox"/> Bus <input type="checkbox"/> <b>Other:</b> Company/Route No:
2. INDEX CASE					
<b>ILLNESS SUSPECTED/PROBABLE/CONFIRMED (CIRCLE ONE):</b> _____					
<b>CLINICAL INFORMATION:</b>					
<b>LABORATORY INFORMATION:</b>					
3. INFORMATION FOR EXPOSED (CONTACT) PASSENGER/TRAVELER					
Last name, First name		Address/Phone/email		Gender	DOB (mm/dd/yy)/Age (yrs)
4. CONTACT INTERVIEW INFORMATION					
<b>Were you able to contact this person?</b>					
<input type="checkbox"/> No, <b>due to:</b> <input type="checkbox"/> Incorrect locating information <input type="checkbox"/> No longer at temporary address but still in U.S. <input type="checkbox"/> No response <input type="checkbox"/> Returned to country of residence <input type="checkbox"/> Didn't attempt follow-up <input type="checkbox"/> Other, specify _____ (Stop here)					
<input type="checkbox"/> Yes, date contacted: ___/___/___					
Was contact interviewed?					
<input type="checkbox"/> No, <b>due to:</b> <input type="checkbox"/> Declined <input type="checkbox"/> Lives in different jurisdiction, specify _____ <input type="checkbox"/> Other, specify _____ (Stop here)					
<input type="checkbox"/> Yes; actual/verified seat/location # _____ <input type="checkbox"/> <b>Unknown</b> <input type="checkbox"/> <b>Does not apply</b>					
Was this person a known close contact of the index case outside of this travel (e.g. family member)? <input type="checkbox"/> No <input type="checkbox"/> Yes: <b>specify</b> _____					
5. IMMUNITY					
Vaccination or history of disease:					
<input type="checkbox"/> Not vaccinated <input type="checkbox"/> <b>Does not apply</b> <input type="checkbox"/> History of disease <input type="checkbox"/> Immunity established by serology <input type="checkbox"/> Unknown					
<input type="checkbox"/> Vaccinated <b>Vaccination Type:</b> _____ <b>Manufacturer:</b> _____ <b>Date of Doses:</b> ___/___/___; ___/___/___; ___/___/___					
6. HEALTH SINCE TRAVEL					
Did contact report any signs or symptoms? <input type="checkbox"/> No <input type="checkbox"/> <b>Yes, Date of earliest symptom onset</b> ___/___/___; check all that apply:					
<input type="checkbox"/> Fever (Max temp measured _____°C/F) <input type="checkbox"/> Cough <input type="checkbox"/> Rash <input type="checkbox"/> Coryza <input type="checkbox"/> Conjunctivitis					
<input type="checkbox"/> Sore throat <input type="checkbox"/> Swollen glands <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Jaundice <input type="checkbox"/> Headache <input type="checkbox"/> Neck stiffness					
<input type="checkbox"/> Unusual bleeding <input type="checkbox"/> Decreased consciousness <input type="checkbox"/> Difficulty breathing/shortness of breath					
<input type="checkbox"/> Recent onset of focal weakness and/or paralysis <input type="checkbox"/> <b>Loss of sense of smell</b> <input type="checkbox"/> <b>Loss of sense of taste</b> <input type="checkbox"/> <b>Fatigue</b>					
<input type="checkbox"/> Other, specify _____					
7. PUBLIC HEALTH INTERVENTION					
Did contact receive prophylaxis for this exposure?					
<input type="checkbox"/> No, <b>due to:</b> <input type="checkbox"/> Outside window for prophylaxis <input type="checkbox"/> Within window for prophylaxis but declined <input type="checkbox"/> Other, specify _____					
<input type="checkbox"/> Yes, please indicate what s/he received and include the date(s):					
<input type="checkbox"/> Antimicrobial drug; specify _____, date received: ___/___/___ <input type="checkbox"/> Vaccination; date received: ___/___/___					
<input type="checkbox"/> Immunoglobulin; date received: ___/___/___ <input type="checkbox"/> Other, specify _____; date received: ___/___/___					
8. DIAGNOSIS					
Was this person diagnosed with the disease in question?					
<input type="checkbox"/> No					
<input type="checkbox"/> Unknown, why? <input type="checkbox"/> Declined medical evaluation <input type="checkbox"/> Not interviewed after incubation period <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Other, specify _____					
<input type="checkbox"/> Yes, how was diagnosis made? (Check all that apply)					
<input type="checkbox"/> IgM <input type="checkbox"/> Paired IgG <input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Epi-linked <input type="checkbox"/> Clinical diagnosis <input type="checkbox"/> Other, specify _____					
Check any of the following potential exposures this person may have had recently for the disease in question:					
<input type="checkbox"/> Exposed to a confirmed case besides the index case					
<input type="checkbox"/> Other, specify _____					
What was the official diagnosis for this person (e.g. confirmed pertussis, active TB, LTBI)? _____					
9. COMMENTS					

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Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-0900.