

## SUPPLEMENTAL/OUT OF JURISDICTION CONTACT FORM

**INDEX PATIENT NAME:**

**DOB:**

**CONTACT INFORMATION**

*If necessary, please include additional sheets w/patient and contact's name(s).*

⇒ Please # each additional contact and collect **COMPLETE** locating information. Fill in text fields and required Disposition Code. Check applicable variables.

Contact Name, City, County or State, Phone Number, Place of Employment and Physical Description	Sex	Date of Last Exposure	Test Date	Date of Treatment	Disposition Code Required *See Below
3.	M <input type="checkbox"/> F <input type="checkbox"/>				
4.	M <input type="checkbox"/> F <input type="checkbox"/>				
5.	M <input type="checkbox"/> F <input type="checkbox"/>				
6.	M <input type="checkbox"/> F <input type="checkbox"/>				
7.	M <input type="checkbox"/> F <input type="checkbox"/>				

**\*Disposition Codes**

- |                                   |  |  |
|-----------------------------------|--|--|
| A. Preventive Treatment           | D. Infected, not Treated                 | G. Insufficient Information to Begin Investigation |
| B. Refused Preventive Treatment   | E. Previously Treated for this Infection | H. Unable to Locate                                |
| C. Infected, Brought to Treatment | F. Not Infected                          | J. Located, Refused Examination                    |
|                                   |  | K. Out of Jurisdiction                             |

Comment Section: