TEXAS Department of State Health Services

Contact Tracking Form

Index or Primary Case Name: Date contacts first contacted: ____/____/____

This contact form is for use with infectious respiratory or invasive disease investigations necessitating contact investigation or follow-up.

Case Status

Name: _____ **DOB:** ____/____/____ **Age:** _____ **Sex:** _____ **Relationship to case**: _____ **Contacted?** ☐ Yes ☐ No

Phone: ( ) _____ **Address**:_____ **City**:_____ **County**:_____ **Zip**:_____

Date of last exposure to case: ____/____/____ **Description of exposure**:_____

Currently vaccinated for this disease? ☐ Yes ☐ No ☐ N/A ☐ Unknown If yes, Date of vaccine: ____/____/____ Vaccine name:_____

Symptoms of illness? ☐ Yes ☐ No ☐ Unknown If yes, Date of onset: ____/____/____ Symptoms:_____

If applicable, received prophylaxis? ☐ Yes ☐ No If yes, Date: ____/____/____ **If applicable, received vaccine?** ☐ Yes ☐ No If yes, Date: ____/____/____

If applicable, specimen collected? ☐ Yes ☐ No If yes: Date of collection: ____/____/____ Sent to DSHS? ☐ Yes ☐ No Result:_____

Comments:_____

☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a Case

Name: _____ **DOB:** ____/____/____ **Age:** _____ **Sex:** _____ **Relationship to case**: _____ **Contacted?** ☐ Yes ☐ No

Phone: ( ) _____ **Address**:_____ **City**:_____ **County**:_____ **Zip**:_____

Date of last exposure to case: ____/____/____ **Description of exposure**:_____

Currently vaccinated for this disease? ☐ Yes ☐ No ☐ N/A ☐ Unknown If yes, Date of vaccine: ____/____/____ Vaccine name:_____

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If applicable, specimen collected? ☐ Yes ☐ No If yes: Date of collection: ____/____/____ Sent to DSHS? ☐ Yes ☐ No Result:_____

Comments:_____

☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a Case

Name: _____ **DOB:** ____/____/____ **Age:** _____ **Sex:** _____ **Relationship to case**: _____ **Contacted?** ☐ Yes ☐ No

Phone: ( ) _____ **Address**:_____ **City**:_____ **County**:_____ **Zip**:_____

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Comments:_____

☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a Case

Name: _____ **DOB:** ____/____/____ **Age:** _____ **Sex:** _____ **Relationship to case**: _____ **Contacted?** ☐ Yes ☐ No

Phone: ( ) _____ **Address**:_____ **City**:_____ **County**:_____ **Zip**:_____

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If applicable, specimen collected? ☐ Yes ☐ No If yes: Date of collection: ____/____/____ Sent to DSHS? ☐ Yes ☐ No Result:_____

Comments:_____

☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a Case