Interjurisdictional Follow-up Form

30 day status: ☐ located ☐ not located

Return to:

_____ Name

_____ Fax number

_____ Jurisdiction

_____ Phone number

Patient name_____ Date of birth ____/___/___
Last First Middle

New address _____
Number Street/Apt. City State Zip Code

New telephone ( )_____ Sex ☐ Male ☐ Female

☐ **Case:** (Send RVCT F/U2 to reporting jurisdiction)

☐ Completed: ____/____/____ ☐ Moved to: city county state

☐ Died ☐ Lost (after initially located) ☐Never located

☐Uncooperative or refused ☐Not TB ☐Other_____

☐**Suspect:**

☐Verified by lab ☐Verified by clinical

☐Verified by provider ☐Not verified

☐Other:_____

If verified, and original jurisdiction submits RVCT, complete case outcome above.

☐**Contact:**

☐No follow-up performed ☐Never located

☐Evaluated: ☐ Class II ☐ Class III ☐Class IV ☐No infection

☐ Started treatment ☐Continuing treatment ☐Other:_____

☐**LTBI/Convertor:**

☐No follow-up performed ☐Never located ☐Started treatment

☐ Continuing treatment ☐Other:_____