Contact Identification Form for Exposure to Communicable Diseases of Urgent Public Health Concern

1. SUSPECT CASE information a. Suspect Case Initials: _____ (IF MORE THAN ONE SUSPECT CASE, USE SEPARATE FORMS)

b. Date Suspect Case Entered Hospital/Clinic: _____/_____/_____

c. Location(s) in Hospital/Facility of Suspect Case and Time Suspect Case Entered Each Location (best estimate):

Location 1:	Time entered:	Location 4:	Time entered:
Location 2:	Time entered:	Location 5:	Time entered:
Location 3:	Time entered:	Location 6:	Time entered:

2. POTENTIAL CONTACTS information

	Last Name	First Name	Age	Gender	Address (street, apt #, city, borough, state, zip code)	Alt Address (e.g., work)	Home phone/ Cell phone / Email Address	Alternate Phone/Cell (e.g., next of kin)	Type of Exposure to Suspect Case (include location)	Duration of Exposure to Suspect Case	If known, vaccine status (note which vaccine preventable illness of concern)
1							---------- -				
2							---------- -				
3							----------				
4							---------- -				
5							---------- -				
6							---------- -				
7							----------				
8											
9							---------- -				
10							---------- -				

SAMPLE

Source: NYC Department of Health and Mental Hygiene (DOHMH)