



## OOJ Field Record

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OOJ State: \_\_\_\_\_ OOI County/Area: \_\_\_\_\_

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
AKA \_\_\_\_\_ DOB \_\_\_\_\_

### Demographics

Birth gender: \_\_\_\_\_ Current gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_

### Physical Description

Height \_\_\_\_\_ Size \_\_\_\_\_ Complexion \_\_\_\_\_ Hair \_\_\_\_\_  
Other: \_\_\_\_\_

### Address:

Street address: \_\_\_\_\_ Unit number \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_ Phone \_\_\_\_\_

Date Initiated: \_\_\_\_\_ Initiating Agency: \_\_\_\_\_

### Expo. Date

First: \_\_\_\_\_ Last: \_\_\_\_\_ Frequency: \_\_\_\_\_

Referral Basis: \_\_\_\_\_ Type Referral: \_\_\_\_\_

Contact to: \_\_\_\_\_ Record Number: \_\_\_\_\_

Co-morbidity? \_\_\_\_

	Date	Return Dispo:	Return Requested by
200 Dispo: _	_____	200 Dispo: _	Date:
300 Dispo: _	_____	300 Dispo: _	
700 Dispo: _	_____	700 Dispo: _	
900 Dispo: _	_____	900 Dispo: _	

Notes \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Labs

## Field Record

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AKA \_\_\_\_\_ DOB \_\_\_\_\_

### Demographics

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### Physical Description

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Other: \_\_\_\_\_

### Address:

Street address: \_\_\_\_\_ Unit number \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_ Phone \_\_\_\_\_

Record Number: \_\_\_\_\_



Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Dear \_\_\_\_\_,

Please call me as soon as possible regarding an important health matter that concerns you. My telephone number is (702) 759-\_\_\_\_\_. The Health District is open from 8:00 a.m. to 4:00 p.m. Monday - Friday. If I am not at my desk when you call, please leave a phone number where you can be reached along with the best time of day for return call. If you wish to contact me via email my email address is: \_\_\_\_\_

Thank you.

Por favor llámeme lo antes posible para un asunto importante acerca de su salud. Mi número de teléfono es (702) 759-\_\_\_\_\_. El Distrito de Salud está abierto de lunes a viernes de 8:00 a.m. a 4:00 p.m. Si no contesto su llamada por favor dejar un mensaje con su nombre, número de teléfono y cuál es la mejor hora para comunicarse con usted. Si prefiere comunicarse conmigo a través del correo electrónico esta es mi dirección: \_\_\_\_\_

Gracias

Sincerely,

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Southern Nevada Health District  
Las Vegas, Nevada  
(702) 759-\_\_\_\_\_ office  
(702) 759-1454 fax  
email: \_\_\_\_\_



Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Dear \_\_\_\_\_,

This letter is to inform you that you have been exposed to someone with pulmonary (lung) tuberculosis. Public health regulations in the state of Nevada (NAC 441A.365) require that a person identified as a contact to an active tuberculosis patient must submit to a complete medical evaluation, which may include a tuberculin skin test, blood test, and/or chest x-ray, if necessary.

Be advised that this evaluation is **mandatory**. The Southern Nevada Health District Tuberculosis Clinic is able to provide this evaluation or you may request this from your preferred provider. At the Southern Nevada Health District, there is no charge for the testing and you do not need an appointment, although appointments are highly recommended, and may be scheduled by calling (702) 759-1370. Our hours for testing are Monday through Friday from 7:00 a.m. until 3:00 p.m.

Please be assured that our staff is prepared to assist you, if necessary, to ensure that you receive this evaluation.

Your cooperation in this matter is appreciated. Please call 702-759-\_\_\_\_\_ or 702-759-1370 should you have any questions regarding this notice.

Sincerely,

\_\_\_\_\_  
\_\_\_\_\_

Southern Nevada Health District

cc: Joseph P. Iser, MD, DrPH, MSc/ Chief Health Officer  
Cassius Lockett, PhD/ Director of Community Health



Date: \_\_\_\_\_

Immigrant Name: \_\_\_\_\_

C/O Sponsor Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Dear Sponsor: \_\_\_\_\_,

The Southern Nevada Health District has been notified by the Centers for Disease Control and Prevention (CDC) of \_\_\_\_\_ arrival. This individual was admitted to the United States on a Class B waiver of excludability. This means that they need additional follow-up to exclude the presence of active tuberculosis. There is a fee for this service.

Please call the TB Clinic at 702-759-1370 no later than \_\_\_\_\_ to make an appointment to begin the immigration clearance process. Our hours are 7:00 a.m. – 4:30 p.m. Monday through Friday. Please bring any paperwork and the x-ray or x-ray CD that was given to the immigrant prior to traveling, when coming in for your appointment.

Please be advised there may be consequences for failure to respond to this notification.

Your cooperation in this matter is appreciated. Please contact us at 702-759-1015 should you have any questions.

Sincerely,

\_\_\_\_\_  
\_\_\_\_\_

Southern Nevada Health District

cc: Joseph P. Iser, MD, DrPH, MSc/ Chief Health Officer  
Cassius Lockett, PhD/ Director of Community Health