



___ Dispo Requested

___ Morbidity Only

___ Needs Ix/Partner Services

___ HIV Linkage services

OOJ Field Record

Worker _____

Record Number: _____ OOI State _____ OOI County _____

Last: _____ First: _____ Middle: _____

AKA _____

DOB _____ Age _____ Birth gender: _____ Current gender: _____ Marital Status: _____

Ethnicity: _____ Race: _____ Height _____ Size _____ Complexion _____ Hair _____

Other _____

Locating information:

Street address: _____ Unit number _____ City _____ State _____

Zip _____ County _____ Phone Number _____

Other _____

Exposure		
First	Frequency	Last

Referral Basis	Disease	Date Initiated	Disposition



Last: _____ First: _____ Middle: _____

Labs:

Treatment:

Comments:

Field Record

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 _____

Record Number: _____



Date: _____

Name: _____

Address: _____

Dear _____,

It is urgent that you report to 280 S. Decatur, Las Vegas, NV 89017 or call me as soon as possible regarding an important matter that concerns you. My telephone number is (702) 759-_____. The Health District is open from 8:00 a.m. to 4:30 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.

Es urgente que lo antes posible se presente en el 280 S Decatur, Las Vegas , NV 89107 o llame 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 4:30 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,

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

cc: Joseph P. Iser, MD, DrPH, MSc/ Chief Health Officer
Michael D. Johnson, PhD/ Director of Community Health



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 8:00 a.m. until 4:30 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
Las Vegas, Nevada
(702) 759-_____ office
(702) 759-1454 fax
email: _____

cc: Joseph P. Iser, MD, DrPH, MSc/ Chief Health Officer
Michael D. Johnson, 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 8:00 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
Las Vegas, Nevada
(702) 759 _____ office
(702) 759-1454 fax
email: _____

cc: Joseph P. Iser, MD, DrPH, MSc/ Chief Health Officer
Michael D. Johnson, PhD/ Director of Community Health