Quarterly Contact Examination Return of Leprosy Patient

ALC/CT/QR/01

Districts:……………………………………………… MOH Office: ………………………………………

PHI area	ALC no	Name of the patient	PB/ MB	SEX M/F	No of contacts identified	No of contacts examined	Number referred to confirmed Leprosy	Number confirmed from referral	Remarks TB/Other
Total									

……………………………………………… ……………………
Name and signature of MOH Date

………………………………………… …………………
Name and signature of SPHI Date

(To be filled by SPHI and to be sent to the Regional Epidemiologist through MOH before 15th of following month)