Reset Form

REPORT OF LATENT TUBERCULOSIS INFECTION (LTBI)

State Form 49894 (R6 / 5-22)
INDIANA DEPARTMENT OF HEALTH

This form contains confidential information per 410 IAC 1-2.5-78.

INSTRUCTIONS: *1. Submit form via NBS or fax completed form to Indiana Department of Health at (317) 233-7747. Telephone number: 317-233-7434*
2. Submit only for newly provider diagnosed latent TB infection (LTBI).
3.All newly diagnosed cases of LTBI shall be reported to the local health officer or the department within one (1) business day in accordance with 410 IAC 1-2.5.

1. Patient name *(Last, First, MI)*

_____

2. Address *(number and street)* _____

_____

City_____ ZIP code_____

County_____

Telephone number (_____) _____

3. Date of birth _____-_____-_____

4. Sex at birth ☐ Male ☐ Female

If female, was individual pregnant at time of evaluation? ☐ Yes ☐ No

5. Race (*check all that apply)*

☐ American Indian or Alaska Native

☐ Asian *(specify)*: _____

☐ Black or African-American

☐ Native Hawaiian or other Pacific Islander *(specify)*: _____

☐ White

☐ Other race *(specify):* _____

6. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

7. Language spoken: _____

FOR LOCAL HEALTH DEPARTMENT USE ONLY

Date received at local health department *(month, day, year)* _____

Reported by_____ Telephone number (____)_____

FOR ALL NON-LOCAL HEALTH DEPARMENT USE ONLY

Reported by _____

Agency _____

Telephone number (____)_____

Attending Physician _____

Telephone number (____)_____

8. Born in the United States? ☐ Yes ☐ No

If no, country of birth _____

Date arrived in the U.S. *(month, day, year)* _____

9. Country of usual residence _____

10. Lived outside of the United States for >2 months uninterrupted? ☐ Yes ☐ No

If yes, list countries: _____

11. Pediatric TB patients (<15 years old)

Country of birth for primary guardian(s) *(specify)*:

Guardian 1 _____

Guardian 2 _____

12. Initial reason evaluated for LTBI *(select one)*

☐ Contact Investigation – Name of case _____ ☐ Targeted Testing

☐ Immigration Medical Exam ☐ Other _____

☐ Employment Testing

13. Previous positive TB skin test (TST) or Interferon Gamma Release Assay (IGRA)? ☐ Yes ☐ No *If yes, year* _____

14. Previous diagnosis of LTBI? ☐ Yes ☐ No *If yes, year* _____

If yes, completed treatment? ☐ Yes ☐ No ☐ Unknown Length of treatment _____

15. TB skin test

☐ Positive ☐ Negative ☐ Not done

Date placed *(month, day, year)* _____

Date read *(month, day, year)* _____

Results _____ mm

16. Interferon Gamma Release Assay

☐ **QuantiFERON (QFT)**

☐ Positive ☐ Negative ☐ Indeterminate ☐ Not done

☐ **T-SPOT**

☐ Positive ☐ Negative ☐ Borderline ☐ Invalid ☐ Not done

Date collected *(month, day, year)* _____

17. Chest X-ray/CT

Initial chest X-ray/CT:

☐ Normal ☐ Abnormal, not consistent with TB ☐ Abnormal, TB disease ruled out

Date of chest X-ray/CT *(month, day, year)* _____ **Previous chest X-ray/CT date** (*month, day, year)* _____

18. HIV status at time of diagnosis *(select one)* **Date of HIV test** *(month, day, year)* _____

☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Refused ☐ Not offered

19. Was the patient diabetic at the time of evaluation? ☐ Yes ☐ No

20. Current smoking or vaping of nicotine products status at time of evaluation?

☐ Current everyday smoker ☐ Current someday smoker

☐ Former smoker ☐ Never smoker

☐ Smoker, current status unknown

21. Has the patient <u>ever</u> worked as one of the following? *(Select all that apply.)*

☐ Health care worker ☐ Migrant / seasonal worker

☐ Correctional facility worker ☐ None of the above

22. What is the patient's current occupation?

☐ Health care worker ☐ Migrant / seasonal worker

☐ Correctional facility worker

☐ Other occupation *(specify)*_____

Place of employment _____

☐ Retired ☐ Unemployed

☐ Not seeking employment (e.g., student, homemaker, disabled person)

☐ Student_____ School _____

23. Has the patient <u>ever</u> been homeless? ☐ Yes ☐ No

If yes, name of facility _____

23a. Has the patient been homeless in the past twelve (12) months? ☐ Yes ☐ No

If yes, name of facility _____

24. Was the patient ever a resident of a correctional facility? ☐ Yes ☐ No

If yes, name, location, and date (month, day, year) of most recent incarceration: _____

24a. Was the patient a resident of a correctional facility at time of evaluation? ☐ Yes ☐ No

If yes, name of facility _____

Type of facility *(Select one.)*

☐ Local jail ☐ State prison ☐ Federal prison ☐ Juvenile correctional facility ☐ Other correctional facility

25. Was the patient a resident of a long-term care facility at time of diagnosis?

☐ Yes ☐ No

If yes, name of facility _____

Type of facility *(Select one.)*

☐ Nursing home ☐ Hospital-based facility

☐ Residential facility ☐ Mental health residential facility

☐ Alcohol or drug treatment facility ☐ Other long-term care facility

26. Additional risk factors *(select all that apply)*

☐ Contact of infectious TB patient (Two (2) years or less) _____

☐ End-stage renal disease at evaluation

☐ Heavy alcohol use in past twelve (12) months

☐ Immunocompromise (not HIV/AIDS)

☐ Injecting drug use in past twelve (12) months

☐ Noninjecting drug use in past twelve (12) months

☐ Post-organ transplantation

☐ TNF-α antagonist therapy

☐ Viral hepatitis B ever

☐ Viral hepatitis C ever

☐ Other *(specify)* _____

27. Based on risk factors for TB exposure or for progression to TB disease, this patient is being treated for: *(select one)*

☐ Window prophylaxis ☐ Treatment for TB Infection

28. Initial Drug Regimen

☐ 3HP (1x Weekly, 12 weeks)
Rifapentine, Dose: _____
Isoniazid, Dose: _____

☐ 4R (Daily, 4 months)
Rifampin, Dose: _____

☐ 3HR (Daily, 3 months)
Rifampin, Dose: _____
Isoniazid, Dose: _____

Alternate Regimens:

☐ Isoniazid, Dose:_____
Frequency: Daily / Twice Weekly
Length: 6 Months / 9 Months

☐ Other, Drug(s) _____ Dose(s): _____
Frequency: _____
Length: _____

29. Patient weight _____ pounds / 2.2 = _____ Kg

30. Date therapy started *(month, day, year)* _____

31. Are you requesting medications through the Indiana Department of Health? ☐ Yes ☐ No

Comments