Reset Form

REPORT OF LATENT TUBERCULOSIS (TB) INFECTION

State Form 49894 (R5 / 1-16)
INDIANA STATE DEPARTMENT OF HEALTH

Information contained on this form is confidential under IC 16-41-8-1.

Submit only for newly provider diagnosed latent TB infection. See instructions for additional guidance.

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

_____

2. Address *(number and street)* _____

_____

City_____ Within city limits? ☐ Yes ☐ No

Telephone (_____)_____

County_____ ZIP Code_____

3. Date of birth _____-_____-_____ **4. Age**_____

5. Sex ☐ Male ☐ Female

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

7. Race (*check all that apply)* ☐ White ☐ Black or African-American

☐ Asian *(specify)* _____

☐ American Indian or Alaska Native

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

FOR LOCAL HEALTH DEPARTMENT USE ONLY

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

Reported by_____ Telephone (____)_____

Reported by _____

Agency _____

Telephone (_____) _____

Attending Physician _____

Telephone (_____) _____

8. If not born in the U.S., country of birth _____ Date arrived in the U.S. *(month, year)*_____--_____

9. Primary Reason Evaluated for LTBI *(select one)*

☐ Contact Investigation – Name of case _____
☐ Health Care Worker
☐ Abnormal Chest Radiograph / Chest CT
☐ Targeted Testing
☐ Employment / Administrative Testing
☐ Incidental Lab Result
☐ Immigration Medical Exam – A#_____

10. Previous positive TST or IGRA? ☐ Yes ☐ No If yes, year _____

11. Previous incomplete LTBI therapy? ☐ Yes ☐ No If yes, year _____

12. TB Mantoux Skin Test (TST)/Interferon Gamma Release Assay (IGRA)

•Mantoux Skin Test ***(For interpretation of TST see Indiana State Tuberculosis Manual at www.TB.IN.gov.)***

Date given *(month, day, year)*_____ **Date read** *(month, day, year)*_____ **Induration size** _____ mm

•IGRA Test Type ☐ QFT-Gold ☐ QFT-IN Tube ☐ T Spot **Date collected** *(month, day, year)* _____

IGRA Results ☐ Positive ☐ Negative ☐ Indeterminate ☐ Borderline ☐ Not Done **IGRA Quantitative Result** _____

13. Chest X-Ray / CT ***(Note: Chest x-ray / CT must be done within the past six (6) months. Written report must be submitted.)***

Initial Chest X-Ray / CT:

☐ Normal ☐ Abnormal, with no evidence of active TB disease ☐ Abnormal, with stable fibrotic lesions consistent with old, healed TB

Date of Chest X-Ray / CT *(month, day, year)* _____ **Previous Chest X-Ray / CT Date** (*month, day, year)* _____

14. HIV Status *(select one)* Date of HIV Test *(month, day, year)* _____ ***(Note: HIV test must be done within past year.)***

☐ Negative ☐ Positive ☐ Indeterminate ☐ Refused ☐ Tested, Results Pending ☐ Not Offered

15. Risk factors for TB Exposure or Progression to Active Disease *(Select all that apply.)*

☐ HIV-infected person

☐ Recent (two (2) years or less) contact to an infectious TB disease

☐ Person with fibrotic changes on chest radiograph consistent with prior TB (calcified granulomas)

☐ Recent immigrants (<5 years from high-prevalence countries)

☐ Resident/employee of a high-risk congregate setting (prisons, jails, nursing homes, long-term care facilities, residential facilities, homeless shelters)

☐ Children < 4 years of age

☐ Infants, children & adolescents exposed to adults in high-risk categories

☐ Persons with certain high-risk medical conditions *(select all that apply)*
☐ Silicosis ☐ Diabetes ☐ Leukemias ☐ Lymphomas
☐ Gastrectomy ☐ Jejunoileal Bypass ☐ End Stage Renal Disease

☐ No known risk factors

☐ TNF-α Antagonist Therapy

☐ Other immunosuppression

☐ Organ transplant recipient

☐ Mycobacteriology laboratory personnel

☐ Recent (within the last 2 years) conversion to TST +

☐ Health Care Worker

☐ Weight loss >10% of ideal body weight

☐ Substance Abuse *(select all that apply)*
☐ Non-injecting drug use
☐ Injecting drug use
☐ Excess alcohol intake

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

☐ Window Prophylaxis ☐ Treatment for TB Infection

Duration of treatment *(select one)*: ☐ Twelve (12) weeks* ☐ Four (4) months ☐ Six (6) months ☐ Nine (9) months

If an alternate regimen is prescribed, please include rationale _____

17. Initial Drug Regimen ☐ Isoniazid, Dose _____ ☐ Vitamin B6, Dose _____ ☐ Rifampin, Dose _____ ☐ Rifapentine*, Dose _____

Note: Make sure you know all prescription and over-the-counter medications patient is on and are aware of potential drug interactions.

18. Patient Weight _____ pounds / 2.2 = _____ Kg

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

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

Submit form to patient's local Health Department.

Comments:

*** MUST USE DIRECTLY OBSERVED THERAPY PER CDC RECOMMENDATIONS.**

Instructions for Completing State Form 49894, Report of Latent Tuberculosis (TB) Infection

This form is only for persons who have been newly diagnosed with latent TB infection and meet the following four criteria:

1. There needs to be a new positive screening test for TB, and
2. There needs to be a negative or normal chest x-ray/CT, and
3. There needs to be no evidence of extrapulmonary tuberculosis, and
4. The individual needs to have a provider diagnosis of LTBI.

Do not use this form for reporting persons who have TB disease or are suspected to have TB disease.

Items 1-7: Each item should be completed and collected as self-report. Check the patient's self-reported sex, race and ethnicity.

Item 8: If the patient was not born in the U.S., enter the country of birth as well as the month and year of arrival in the U.S.

Item 9: Primary Reason Evaluated for LTBI: check the primary reason (select only one) why the patient was evaluated for TB infection.

- **Contact Investigation** (Check if evaluation was a result of contact investigation or source case finding.)
- **Abnormal Chest Radiograph** (Check if evaluation was due to abnormal CXR/CT. List results in item 13.)
- **Targeted Testing** (Check if patient was part of a targeted testing screening program.)
- **Health Care Worker** (Check if evaluation was done due to positive TST or Interferon Gamma Release Assay (IGRA) through baseline or annual testing.)
- **Employment / Administrative Testing** (Check if evaluation was a result of routine employment physical exam, employment requirements, or primary or secondary school routine testing.)
- **Incidental Lab Result** (Check if notification was a result of incidental specimen collected which was then found to be without suspicion of TB disease or when TB disease was not considered a possible diagnosis.)
- **Immigration Medical Exam** (Check if evaluation was done as part of immigration application process either here in the U.S. or overseas.)

Items 10-11: Check appropriate box, and list year.

Item 12: Enter date given, date read, and size of TST induration (in millimeters) or IGRA test (QFT-Gold, QFT-IN Tube, T-Spot, etc.) and the appropriate results (results and date administered or blood drawn).

Item 13: Check CXR and CT results as appropriate. If comparisons to prior CXR or CT were made, indicate dates of comparison.

Item 14: Enter the information and date for HIV testing. (Note: HIV test must have been done within the past year.)
Do not leave blank.

Item 15: Check all that apply. Indicate any additional risk factors the patient may have.

Item 16: Check appropriate box, include duration of treatment.

Item 17: Check appropriate box(es) and list dosage(s).

Item 18: List patient's current weight.

Item #19: List month, day, and year therapy started.

Item #20: Check yes or no if you are requesting medications through the Indiana State Department of Health.

Submit the report to the patient's local health department.
Do not send directly to the Indiana State Department of Health.