REPORT OF TREATMENT FOR LATENT TB INFECTION

State Form 49894 (R4 / 11-10)
INDIANA STATE DEPARTMENT OF HEALTH

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

INSTRUCTIONS: ***1. Submit only for persons being treated for latent TB infection who are requesting drugs through ISDH.***
2. Submit with prescriptions and chest x-ray report to local health department.
3. Do not use to report verified or suspected cases of TB disease.

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 to TB case Name of case _____

☐ Contact Investigation

☐ Abnormal Chest Radiograph

☐ Targeted Testing

☐ Health Care Worker

☐ Employment/Resident of high-risk congregate setting

☐ Incidental Lab Result

☐ Immigration Medical Exam

☐ Refugee Screening/Class B Follow Up 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 ***(Note: Chest x-ray must be done within the past six (6) months. Written report must be submitted with medication requests.)***

Initial Chest X-Ray:

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

Date of Chest X-Ray *(month, day, year)* _____ **Previous Chest X-Ray 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 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 (≥ 15 mg/d prednisone for one month or more)

☐ 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)* ☐ 4 months ☐ 6 months ☐ 9 months

Note: Nine (9) months of Isoniazid is the preferred regimen for all patients.

If an alternate regimen is prescribed, please include rationale _____

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

Comments:

ONLY REGIMENS RECOMMENDED BY THE AMERICAN THORACIC SOCIETY WILL BE PROVIDED.

Send with ISDH Drug Request Form, prescription and chest x-ray report to:

Indiana State Department of Health
2 North Meridian Street, Section 6-D
Indianapolis, IN 46204
Phone: (317) 233-7434 Fax: (317) 233-7747