

LATENT TUBERCULOSIS INFECTION (LTBI) REPORT FORM

SOUTH DAKOTA DEPARTMENT OF HEALTH



REPORTABLE TB RISK FACTORS (check all that apply)

- | | |
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| <input type="checkbox"/> Foreign-born persons who entered the US within last 5 years | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Persons evaluated for tumor necrosis factor-alpha therapy | <input type="checkbox"/> Renal dialysis |
| <input type="checkbox"/> Immunosuppressive therapies (i.e. high dose steroids) | <input type="checkbox"/> Silicosis |
| <input type="checkbox"/> Radiographic evidence of prior TB | <input type="checkbox"/> Organ transplant |
| <input type="checkbox"/> Children less than 5 years of age | <input type="checkbox"/> Head and neck cancers |
| <input type="checkbox"/> Close contact to infectious TB | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> HIV infection | <input type="checkbox"/> Hodgkin's disease |

Please only report patients with latent TB infection who have at least one of the above risk factors.

Report by telephone: 1-800-592-1804 (confidential answering machine)
 Report by fax: (605) 773-5509 (confidential fax)
 Report by mail: South Dakota Department of Health
 Tuberculosis Control Program
 615 East 4th Street
 Pierre, SD 57501

Questions may be directed to the TB Control Program at 1-800-592-1861 or (605) 773-3737.

I. PATIENT DEMOGRAPHICS

Last Name _____ First Name _____
 Address _____ Date of Birth _____ Age _____
 City _____ State _____ Zip Code _____ County _____
 Home phone _____ Work phone _____ Cell phone _____
 Employer _____ Telephone # _____ Occupation _____

Sex: Male Female
Race: White Black Native American Asian
Ethnicity: Hispanic Non-Hispanic

Foreign Born: No Yes If yes, country of birth _____ Date of entry into US _____
(Required if foreign-born)

Clinic Name _____ Telephone # _____ Medicaid eligible: No Yes
 Physician _____ Fax # _____ If yes, Medicaid # _____

II. TB SCREENING INFORMATION

Select the TB screening test that was used to diagnose latent TB infection.

TB skin test **IGRA (Interferon Gamma Release Assay)**

Date of TB skin test _____ Date of blood collection _____

Result: _____ mm Result: Positive Negative Indeterminate

Check One: Reactor
 Convertor If convertor, date of last negative test <2 years ago _____ mm
 Contact If contact, name of TB case that exposed patient _____

III. CHEST X-RAY INFORMATION

Date of the chest X-ray _____ Results _____

IV. TREATMENT INFORMATION

Treatment for LTBI to be started? Yes No Date started _____
 Reason why _____

If yes, therapy prescribed: INH _____ mg daily or twice weekly for _____ months
 Rifampin _____ mg daily for _____ months
 Vitamin B-6 _____ mg daily or twice weekly for _____ months
 Other _____

Medication provider: Dept. of Health (name & location) _____
 Other agency/facility (name & location) _____
 Telephone number _____ Contact Person _____