

LATENT TUBERCULOSIS INFECTION (LTBI) REPORT FORM

SOUTH DAKOTA DEPARTMENT OF HEALTH



REPORTABLE TB RISK FACTORS (check all that apply)

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

- | | |
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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 or long-term steroids) | <input type="checkbox"/> Silicosis |
| <input type="checkbox"/> Radiographic evidence of prior TB | <input type="checkbox"/> Organ transplant |
| <input type="checkbox"/> Patients less than 5 years of age | <input type="checkbox"/> Head and neck cancers |
| <input type="checkbox"/> HIV infection | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Close contact (Defined as confirmed exposure in the last 12 months) | <input type="checkbox"/> Hodgkin's disease |
- (Name of TB source case must be documented in Section II below)

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 _____