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:

- ☐ Foreign-born persons who entered the US within last 5 years
- ☐ Persons evaluated for tumor necrosis factor-alpha therapy
- ☐ Immunosuppressive therapies (i.e. high dose or long-term steroids)
- ☐ Radiographic evidence of prior TB
- ☐ Patients less than 5 years of age
- ☐ HIV infection
- ☐ Close contact (Defined as confirmed exposure in the last 12 months) (Name of TB source case must be documented in Section II below)
- ☐ Diabetes
- ☐ Renal dialysis
- ☐ Silicosis
- ☐ Organ transplant
- ☐ Head and neck cancers
- ☐ Leukemia
- ☐ Hodgkin's disease

Report by telephone: 1-800-592-1861
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 ☐ Native American ☐ Black ☐ 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**
Date of TB skin test ______________
Result: ________ mm

☐ **IGRA (Interferon Gamma Release Assay)**
Date of blood collection ______________
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 Date started ______________
☐ No 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 ______________