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**
- ☐ **Radiographic evidence of prior TB**
- ☐ **Children 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 2 below)
- ☐ **Diabetes**
- ☐ **Renal dialysis**
- ☐ **Silicosis**
- ☐ **Organ transplant**
- ☐ **Head and neck cancers**
- ☐ **Leukemia**
- ☐ **Hodgkin's disease**

Report by fax: (605) 773-5509

TB Program questions: 1-800-592-1861 or (605) 773-3737

Report by mail: Tuberculosis Control Program
South Dakota Department of Health
615 East 4th Street
Pierre, SD 57501

1. PATIENT DEMOGRAPHICS

Last Name _____ First Name _____
Address _____ Date of Birth _____ Age _____
City_____ State _____ Zip Code _____ County _____
Home phone _____ Work phone _____ Cell phone _____
Parent/Guardian _____ Employer _____ Telephone # _____

Gender
☐ Male ☐ Female

Race
☐ White ☐ Native American ☐ Black ☐ Asian

Ethnicity
☐ Non-Hispanic ☐ Hispanic

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

Clinic Name _____ Telephone # _____
Physician _____ Fax #_____ Patient Weight _____Lbs.

2. TB SCREENING INFORMATION

Screening test:
☐ **TB skin test**
Date of test _____
Result: _____ mm

☐ **IGRA (Interferon Gamma Release Assay)**
Date of blood collection _____
Result: ☐Positive ☐ Negative ☐ Indeterminate

Classification:
☐ Reactor
☐ Convertor Date of last negative test <2 years ago _____ mm
☐ Contact Name of TB case that exposed patient _____

3. CHEST X-RAY INFORMATION

Date of the chest X-ray _____ Results_____

4. TREATMENT INFORMATION

Starting Treatment? □ No, Reason why _____ □ Yes, Date started _____

Therapy Prescribed:

□ INH and Rifapentine (3HP)	Once weekly for 12 doses (3 months)
□ Rifampin	Daily for 4 months
□ Isoniazid (INH)	□ Daily or □ Twice weekly □ 6 months or □ 9 months
□ INH and Rifampin (3HR)	Daily for 3 months
□ Vitamin B-6	□ Daily □ Weekly □ Twice weekly □ 3 months □ 6 months □ 9 months

Medication Provider:
☐ Department of Health (Name & Location) _____
☐ Other facility (Name, Location & Phone) _____