DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44125 (Rev. 06/2018)

STATE OF WISCONSIN
Wis. Stat. §. 252.10(7)
608-266-4858

LATENT TUBERCULOSIS INFECTION (LTBI) FOLLOW-UP REPORT

Return the completed form when the client completes a recommended course of therapy or discontinues treatment. Completion of this form is required.

Information can be uploaded into WEDSS
or completed form can be mailed or faxed to:

Public Health Madison & Dane County
2300 S. Park St
Suite 2010
Madison, WI 53713

FAX: (608) 266-4858

Client Name (last, first, middle initial)	Date of Birth (mm/dd/yyyy)
Client Address (street, city, zip code)	

Latent Tuberculosis Determination *(check all that apply)*

☐ **IGRA (Quantiferon or TSPOT) interpretation**
☐ positive ☐ negative ☐ indeterminate
☐ borderline

☐ **Tuberculin Skin Test Interpretation**
☐ positive ☐ negative

☐ **Chest Imaging results**
☐ consistent with TB ☐ not consistent with TB

☐ ***Mycobacterium tuberculosis* complex (MTBC) culture results**
☐ MTBC detected ☐ MTBC not detected

Latent Tuberculosis Treatment

Medication	Medication start date	Medication stop date	Completed according to CDC criteria?
☐ Isoniazid			☐ Yes ☐ No
☐ Rifampin			☐ Yes ☐ No
☐ Isoniazid and rifapentine (3HP)			☐ Yes ☐ No
☐ Other _____			☐ Yes ☐ No

Disposition

Did patient complete an adequate treatment regimen? ☐ Yes ☐ No

Was treatment regimen completed using Directly Observed Therapy (either in person or virtual) ☐ Yes ☐ No

If No, select reason:

☐ Death ☐ Patient moved (follow-up unknown) ☐ Active TB developed
☐ Adverse effect of medicine ☐ Patient chose to stop ☐ Patient is lost to follow-up
☐ Provider decision

Service Provider

Name of Provider (Print)	Assessment Date
Facility Name	Phone Number - -
Street Address	City, State, Zip code
SIGNATURE - Provider	Date Signed