

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)
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Client Address (street, city, zip code)

Latent Tuberculosis Determination (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> IGRA (Quantiferon or TSPOT) interpretation
<input type="checkbox"/> positive <input type="checkbox"/> negative <input type="checkbox"/> indeterminate
<input type="checkbox"/> borderline | <input type="checkbox"/> Tuberculin Skin Test Interpretation
<input type="checkbox"/> positive <input type="checkbox"/> negative |
| <input type="checkbox"/> Chest Imaging results
<input type="checkbox"/> consistent with TB <input type="checkbox"/> not consistent with TB | <input type="checkbox"/> <i>Mycobacterium tuberculosis</i> complex (MTBC) culture results
<input type="checkbox"/> MTBC detected <input type="checkbox"/> MTBC not detected |

Latent Tuberculosis Treatment

Medication	Medication start date	Medication stop date	Completed according to CDC criteria?
<input type="checkbox"/> Isoniazid			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Rifampin			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Isoniazid and rifapentine (3HP)			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other _____			<input type="checkbox"/> Yes <input type="checkbox"/> No

Disposition

Did patient complete an adequate treatment regimen? Yes No

If No, select reason:

- | | | |
|---|--|---|
| <input type="checkbox"/> Death | <input type="checkbox"/> Patient moved (follow-up unknown) | <input type="checkbox"/> Active TB developed |
| <input type="checkbox"/> Adverse effect of medicine | <input type="checkbox"/> Patient chose to stop | <input type="checkbox"/> Patient is lost to follow-up |
| <input type="checkbox"/> Provider decision | | |

Service Provider

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

Date Signed