

## LATENT TUBERCULOSIS INFECTION (LTBI) FOLLOW-UP REPORT

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

Local Health Department – Name and Address

**Return to:**

The Local Health Department in which patient resides.

Or upload to WEDSS

For information, contact the  
Wisconsin TB Program 608-261-6319

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?
<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:

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