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| Patient Demographic Information: | | | | | | |
| Last Name: | | First Name: | | | Middle Name/Initial: | |
| Street/Apt: | | | | | City/Town: | |
| State: | Zip Code: | County: | | | Phone: | |
| Date of Birth: | | Current Sex:  Male Female Unknown | | | Pregnancy Status:  Yes No Unknown | |
| Race:  American Indian/Alaska Native Asian Black or African  American Native Hawaiian or Other Pacific Islander White  Unknown Other: | | | | | Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown | |
| Nativity Information: | | | | | | |
| Country of Birth: | | | | If not U.S., Date of Arrival: | | |
| Unknown | | | | Unknown | | |
| Country of Usual Residence: | | | | If not U.S., have been in U.S. ≥ 90 days?  Yes No Unknown | | |
| Unknown | | | |
| Eligible for Citizenship/Nationality at Birth (regardless of country of birth):  Yes  No  Unknown | | | | | | |
| If Under 15 Years Old, List Countries of Birth for Primary Guardians: | | | Guardian 1:  Guardian 2: | | | Unknown  Unknown |

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| Reporting Agency Information: | | | | |
| Facility Name: | | Provider: | | Date of Assessment: |
| Street/Apt: | | | | City/Town: |
| State: | Zip Code: | County: | | Phone: |
| Date Reported to VDH: | | | Type of Report: Phone Fax Email  Lab via ELR | |

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| Contact, Diagnosis, and Treatment History | | |
| Known contact to a person with TB disease: Yes, Recent  Yes, Historic No Unknown | | |
| If yes, name and location: | | RVCT#: |
| History of prior positive TB test (TST or IGRA): Yes, date: | No Unknown | |
| History of previous diagnosis of TB or LTBI: Yes, TB  Yes, LTBI No Unknown | | |
| History of treatment for TB or LTBI: Yes, TB  Yes, LTBI No Unknown | | |
| If treatment was received for TB or LTBI, describe what is known about past treatment (date, duration, regimen, location, completion status): | | |

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| Reason for LTBI Testing | |
| Screening (check all that apply)  Health Care Worker Testing for other employment Testing for School  Immigrant or Refugee Immunosuppression Resident of Congregate Setting  Other: | |
| TB Symptoms  Cough lasting >3 weeks Coughing up phlegm or blood Chest pain Weakness/Fatigue  Poor appetite Weight loss Fever/Chills Night sweats  🡪 If TB symptoms present, was TB disease clinically ruled out? Yes No\*\* | |
| Reason for Testing Unknown | Other Reason for Testing: |

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| Occupation/Industry Risk Factors (Check all that currently or have *ever* applied): | | |
| Health Care Worker Correctional Facility Employee  Migrant/Seasonal Worker None of These Unknown | | Current Occupation: |
| Other Risk Factors: | | |
| Diabetic at time of evaluation?  Yes  No  Unknown | Heavy alcohol use in the past 12 months?  Yes  No  Unknown | |
| Homelessness in the past 12 months  Yes  No  Unknown | TNF-alpha antagonist therapy  Yes  No  Unknown | |
| Ever experienced homelessness?  Yes  No  Unknown | Post-organ transplant?  Yes  No  Unknown | |
| Resident of correctional facility at evaluation?1  Yes  No  Unknown | End stage renal disease?  Yes  No  Unknown | |
| Has ever been a resident of a correctional facility?  Yes  No  Unknown | Viral Hepatitis (B or C only)?  Yes  No  Unknown | |
| Long-term care facility resident at evaluation? 2  Yes  No  Unknown | Other Immunocompromise?  Yes  No  Unknown | |
| Injecting drug use in the past 12 months?  Yes  No  Unknown | Lived outside U.S. >2 months (uninterrupted)? 3  Yes  No  Unknown | |
| Non-injecting drug use in the past 12 months?  Yes  No  Unknown | Other: | |
| Current smoking status at time of diagnostic evaluation?  Daily Some days Former Never Smoker (Amount Unknown) Status Unknown | | |
| 1If resident of correctional facility at time of evaluation, indicate type of facility:  Federal Prison  State Prison  Local Jail Juvenile Correction Facility  Unknown  Other Correctional Facility, Specify: | | |
| 2If resident of long-term care facility at time of evaluation, indicate type of facility:  Nursing Home Hospital-Based Facility  Residential Facility  Alcohol/Drug Treatment Facility Unknown  Other Long-Term Care Facility, Specify: | | |
| 3If ever lived outside of the United States for >2 months (uninterrupted), list location(s): | | |

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| Tuberculosis Testing | | | | | | | | |
| Tuberculin Skin Test (TST) | Date Placed: | | Date Read: | | | | Not Done | |
| Result (mm of Induration): | | | | Interpretation: Positive Negative | | | |
| Interferon Gamma Release Assay (IGRA) | Date Collected: | | | Test Type: QFT T-SPOT | | | | Not Done |
| Result: Positive Negative Indeterminant/Borderline/Invalid | | | | | | | |
| Was a second TB test performed?  No  Ordered  Yes, see below | | | | | | | | |
| Tuberculin Skin Test (TST) | Date Placed: | | Date Read: | | | | Not Done | |
| Result (mm of Induration): | | | | Interpretation: Positive Negative | | | |
| Interferon Gamma Release Assay (IGRA) | Date Collected: | | | Test Type: QFT T-SPOT | | | | Not Done |
| Result: Positive Negative Indeterminant/Borderline/Invalid | | | | | | | |
| Chest Radiography | | | | | | | | |
| Chest X-Ray | | Date of Exam: | | | | Not Performed | | |
| Findings: Unknown Not consistent w/TB  Consistent with TB 🡪 Cavities Miliary Other  If chest x-ray abnormal, was TB disease ruled out? Yes No\*\* | | | | | | |
| Chest CT | | Date of Exam: | | | | Not Performed | | |
| Findings: Unknown Not consistent w/TB  Consistent with TB 🡪 Cavities Miliary Other  If chest CT abnormal, was TB disease ruled out? Yes No\*\* | | | | | | |

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| Microbiology | | | | | | | | | | |
| Microbiology Not Indicated | | Microbiology Performed (see below) | | | | | | | | |
| Date Collected | Source | AFB Smear | | | PCR/NAAT | | | Culture | | |
| POS | NEG | UNK | POS | NEG | UNK | POS | NEG | UNK |
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| Diagnosis | | |
| Diagnosis of LTBI, Date: | Needs Further Evaluation | LTBI Ruled Out |
| Other/Notes: | | |

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| Treatment Plan | |
| **Treat in Office 🡪** Therapy Start Date:  Isoniazid (9 mo) Isoniazid (6 mo) Isoniazid/Rifapentine (3mo, weekly) Rifampin (4mo)  Isoniazid/Rifampin (3mo, daily) Other, Specify: | |
| **Refer for Evaluation/Treatment, Specify:** | |
| **No Treatment**  **(If “no” indicate reason) 🡪** | Lost to follow-up  Prior TB/LTBI treatment  Medically contraindicated Treatment not offered due to local guidelines Provider decision not to treat Drug shortage  Patient refused  Other |

**\*\*** If TB disease has not yet been ruled out, do not start LTBI treatment. Report suspect active TB disease

to the Vermont Department of Health TB Program at (802) 863-7240.

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| Notes/Comments: |

**Fax or mail completed LTBI report to the Vermont Department of Health**

**Secure Fax:** (802) 951-4061

**Mail:** 280 State Drive, Waterbury, VT 05671-8390

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| Investigation Summary (DEPARTMENT OF HEALTH USE ONLY) | |
| Jurisdiction: | Date Assigned to County: |
| Investigator: | Investigation Start Date: |
| Investigation Information Obtained Via:  Records Review Submission of Form by Provider Outreach to Provider Office | |
| If outreach to provider office, date provider or their representative was reached: | |
| If outreach to provider office, what type of interaction occurred (check all that apply):  Collected data for LTBI report Shared LTBI diagnosis and treatment guidance/tools  Shared patient education resources Directed to provider to clinical resources  (Such as referral to contact local/regional TB experts) | |
| Investigation Notes: | |

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| Latent TB Treatment Follow-Up (DEPARTMENT OF HEALTH USE ONLY)  Complete outcome information after projected end date based on treatment plan above | | | |
| Date Therapy Stopped: | | Administration: DOT eDOT SAT | |
| Reason LTBI Therapy Stopped:  Completed Treatment  Lost to Follow-Up  Patient Choice to Stop  Pregnancy Transferred Care  Not LTBI (clinical decision)  Other, Specify:  Developed TB disease, SCID:  Severe Adverse Event:  🡪  Hospitalized  Died  Reported to CDC (LTBIDRUGEVENTS@CDC.GOV) | | | |
| If care was transferred, please provide the following information about the practice: | | | |
| Name: | City/State: | | Unknown |
| Were there delays in treatment or change to the treatment plan during therapy?  Yes  No  If yes, explain: | | | |
| Notes/Comments: | | | |