|  |
| --- |
| 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 |

|  |
| --- |
| 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  |

|  |
| --- |
| 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):  |

|  |
| --- |
| 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: |

|  |
| --- |
| 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): |

|  |
| --- |
| 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\*\* |

|  |
| --- |
| 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 |
|  |  |  [ ]  |  [ ]  |  [ ]  |  [ ]  |  [ ]  |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
|  |  |  [ ]  |  [ ]  |  [ ]  |  [ ]  |  [ ]  |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
|  |  |  [ ]  |  [ ]   |  [ ]  |  [ ]  |  [ ]   |  [ ]  |  [ ]  |  [ ]   |  [ ]  |

|  |
| --- |
| Diagnosis |
| [ ]  Diagnosis of LTBI, Date:  | [ ]  Needs Further Evaluation | [ ]  LTBI Ruled Out |
| Other/Notes: |

|  |
| --- |
| 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.

|  |
| --- |
| 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

|  |
| --- |
| 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:  |

|  |
| --- |
| 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 [ ]  NoIf yes, explain:  |
| Notes/Comments:  |