RHODE ISLAND DEPARTMENT OF HEALTH
DIVISION OF INFECTIOUS DISEASE AND EPIDEMIOLOGY
TUBERCULOSIS PROGRAM, 3 Capitol Hill, Room 106, Providence, RI 02908
TEL: (401) 222-2577 FAX: (401) 222-2478

CONFIDENTIAL REPORT FOR LATENT TUBERCULOSIS INFECTION (LTBI)

Mail or fax completed report for LTBI within 4 days of recognition

DEMOGRAPHICS

Last Name: | **First Name:** | **DOB (mm/dd/yyyy):** _______ /_______/_______

Street/Apt: | **City:**

State and Zip Code: | **Phone:**

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: (select one or more)
☐ American Indian or Alaska Native
☐ Asian: (specify)_____________________
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander: (specify)______________
☐ White

Country of Birth:
☐ US
☐ Not U.S.: (specify)___________________________

Month-Year arrived in U.S.: (mm/yyyy) _______/________

Sex: ☐ Male ☐ Female

Is the patient a contact to an active TB case? ☐ Yes ☐ No **If yes, name index case, if known:** ________________________________

DIAGNOSIS INFORMATION

Reason for TB Evaluation (check all that apply)
☐ TB Signs/Symptoms
☐ Health Care Worker
☐ Resident of Congregate Setting
☐ Testing for School
☐ Testing for Employment (other than health care worker)
☐ Immigrant or Refugee
☐ Homeless
☐ Contact to Active TB Case (specify index case above)
☐ Immunosuppression (specify) ____________________________
☐ Other (specify) ____

Mantoux Test Results

1st **Date Placed: (mm/dd/yyyy)** ______ /______ /_______ **Date Read: (mm/dd/yyyy)** ______ /______ /______

☐ Positive ☐ Negative **Millimeters (mm) of induration**: _________ ☐ Not Done

2nd **Date Placed: (mm/dd/yyyy)** ______ /______ /_______ **Date Read: (mm/dd/yyyy)** ______ /______ /_______

☐ Positive ☐ Negative **Millimeters (mm) of induration**: _________ ☐ Not Done

Interferon Gamma Release Assay (IGRA) Results

1st **Date Collected: (mm/dd/yyyy)** ______ /______ /__________ **Specify Test Type**: ________________________

☐ Positive ☐ Negative ☐ Indeterminate ☐ Not Done

2nd **Date Collected: (mm/dd/yyyy)** ______ /______ /__________ **Specify Test Type**: _______________________

☐ Positive ☐ Negative ☐ Indeterminate ☐ Not Done

Chest X-Ray **Date: (mm/dd/yyyy)** ______ /______ /_________ ☐ Normal ☐ Abnormal ☐ Not Done

Chest CT Scan **Date: (mm/dd/yyyy)** ______ /______ /_________ ☐ Normal ☐ Abnormal ☐ Not Done

Status ☐ Recent Converter ☐ Infected ☐Not Infected

TREATMENT PLAN

☐ Treat in office
Date Therapy Started (mm/dd/yyyy) ____ /____ /______ **Date of Expected Therapy Completion* (mm/dd/yyyy)** ____ /____ /_______
Drug Regimen: ☐ Isoniazid, Daily for 6 months ☐ Rifampin, Daily for 4 months
☐ Isoniazid, Daily for 9 months ☐ Other (specify): _____________

☐ Refer for Evaluation
Referred to: ☐ RISE TB Clinic ☐ Hasbro TB Clinic ☐ Other (specify) ________________________

☐ No Treatment
Reason: ☐ Pregnant ☐ Previously Treated ☐ Patient Refused ☐ Other (specify) _________________

REPORTING INFORMATION

Reported by:	**Telephone number of reporter:**
Physician caring for patient:	**Telephone number of physician:**
Reporting facility:	**Date of report:** ______ /______ /__________

***LTBI COMPLETION OF THERAPY REPORT FORM MUST BE SENT TO RI DOH UPON PATIENT COMPLETION (OR DISCONTINUATION) OF THERAPY.**