

To Whom It May Concern,

The following patient has been under the care of the Health Department for tuberculosis treatment.

Tuberculosis Treatment Summary

Patient name		Date of birth	
Diagnosis			
Date of test for TB infection		<input type="checkbox"/> IGRA <input type="checkbox"/> TST	<input type="checkbox"/> Positive <input type="checkbox"/> Negative mm:

Culture confirmed case	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, susceptibility results	

Treatment dates		to	
Total treatment length in weeks		Treatment by directly observed therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment Regimen			
Medication	Dose	Start	Stop

Radiology results at treatment completion	
Date	
Impression/findings	

Recommendations:

1. No further tests for TB infection (TST-tuberculin skin test or IGRA-interferon gamma release assay).
2. Seek medical care for symptoms of active TB disease, such as coughing for three weeks or more, coughing up blood, unexplained fevers or weight loss, poor appetite, night sweats, or serious fatigue.
3. For future TB screenings, a chest x-ray should only be necessary if exhibiting symptoms of active TB disease or as recommended by a physician.
4. Keep this letter in a safe place. Take a copy to future TB screenings.

Date:

Public Health Nurse

Phone/Fax/Email:

Treating Clinician(s):