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 | |  | IGRA TST | | Positive Negative | | mm: |

|  |  |  |
| --- | --- | --- |
| Culture confirmed case | Yes No | |
| If yes, susceptibility results | |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Treatment dates |  | | | | | to |  | | |
| Total treatment length in weeks | | |  | Treatment by directly observed therapy | | | | | Yes No |
| Treatment Regimen | | | | | | | | | |
| Medication | | Dose | | | Start | | | Stop | |
|  | |  | | |  | | |  | |
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| --- | --- |
| 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.

PHN Name, Credentials/Title Date:

Phone/Fax/Email:

Treating Clinician(s):