Latent TB. Active Concern.
Tuberculosis Program
VIRGINIA DEPARTMENT OF HEALTH

☐ Initial Report ☐ Follow-up Report

Virginia Latent Tuberculosis Infection (LTBI) Reporting Form

Please use this form to provide initial or follow-up information for persons with suspected or confirmed LTBI.

Initial testing provider information:
Name: _____ **Affiliation/Organization:**_____ **Phone:**_____

Patient Information

Last name	**First name**	**Middle**	**Date of birth** (MM/DD/YYYY)	**Sex at birth** ☐ Male ☐ Female ☐ Unknown

Address	**Unit #**	**City or Town**	**State**	**Zip code**	**County of residence**

Patient telephone number	**U.S.- born** ☐Yes ☐No	**Country of birth**	**Month/Year arrived in U.S.**	**Occupation**

Race (*select all that apply*)
☐American Indian or Alaskan Native ☐ Asian
☐ Black or African-American ☐Native Hawaiian/Other Pacific Islander
☐ White ☐ Other Race ☐ Unknown

Ethnicity
☐Hispanic or Latino
☐Not Hispanic or Latino
☐Unknown

Currently Pregnant?
☐Yes ☐ N/A
☐No

Risk factors

Risk factors (*check all that apply)*
☐ Diabetes ☐ Homeless in past 12 months ☐ Homeless ever ☐ Resident of correctional facility at diagnostic evaluation
☐ Resident of correctional facility ever ☐ Resident of long-term care facility at diagnostic evaluation
☐ Injecting drug use in past 12 months ☐ Noninjecting drug use in past 12 months ☐ Heavy alcohol use in past 12 months
☐ TNF antagonist therapy ☐ Post-organ transplantation ☐ End Stage Renal Disease ☐ Viral Hepatitis (B or C)
☐ Other immunocompromise (other than HIV/AIDS) ☐ Other Risk Factor Specify:_____

Initial reason evaluated for TB (*select one)*
☐ Contact investigation
☐ Screening
☐ TB Symptoms
☐ Other:_____
☐ Unknown

HIV Status at diagnosis
☐ Negative
☐ Positive
☐ Unknown

Current Smoking Status
☐ Current everyday smoker
☐ Current someday smoker
☐ Former smoker
☐ Never smoker
☐ Smoker, current status unknown
☐ Unknown if ever smoked

Was this a TB classified individual?
☐No ☐Yes If Yes: ☐B0 ☐B1 ☐B2 ☐B3

Testing and Evaluation

TST
Date placed: _____
Date read: _____
Induration: _____mm
Interpretation:
☐ Positive ☐ Unknown
☐ Negative ☐ Not done

IGRA
Test date: _____
Test type: ☐ QFT ☐ T-SPOT ☐ Other
Interpretation: ☐ Positive ☐Negative
☐ Unknown ☐ Borderline/Indeterminate
☐ Not done ☐ Failed/Invalid

Sputum Smear
Collection Date: _____
Result: ☐ Positive ☐ Negative
☐ Unknown ☐ Not Done

Sputum Culture
Collection Date: _____
Result: ☐ Positive ☐ Negative
☐ Unknown ☐ Not Done

Additional Specimens Collected? Y/N/U

Date of chest radiography or other chest imaging: _____ **Result** ☐ Consistent with TB ☐ Not consistent with TB ☐ Unknown ☐ Not Done

Treatment

Was the patient offered LTBI treatment? ☐ Yes ☐ No **Did the patient start LTBI treatment?** ☐ Yes ☐ No

Treating Provider Type: ☐ Health Department ☐ Federally Qualified Health Center (FQHC) ☐ Private Provider ☐ Urgent Care
☐ Other Specify_____

Reason patient did not start LTBI treatment (*select one)*
☐ Patient refused
☐ Provider decision
☐ Previous LTBI treatment
☐ Previous TB treatment
☐ Lost to follow-up
☐ Medically contraindicated
☐ Drug shortage
☐ Other: _____
☐ Referred for treatment
Referral: _____

LTBI treatment regimen prescribed (*select one)*
☐ 3 months isoniazid/ rifapentine (3HP)
☐ 4 months rifampin
☐ 6 months isoniazid
☐ Other: _____
☐ 3 months isoniazid/ rifampin (3HR)
☐ 2 months RIPE/HRZE
☐ 9 months isoniazid

LTBI treatment start date	**LTBI treatment end date**

Treatment Administration (*check all that apply)*
☐ DOT (Directly Observed Therapy, in person)
☐ Electronic DOT ☐ Self-Administered ☐ Unknown

Reason LTBI treatment stopped (*select one)*
☐ Complete Treatment
☐ Developed Active TB
☐ Lost to follow-up
☐ Not LTBI (Clinician Decision)
☐ Other: _____
☐ Patient choice
☐ Pregnancy
☐ Severe Adverse Event
☐ Unknown

Fax completed forms to VDH TB Program at 804-416-5178 or send with encrypted email to tuberculosis@vdh.virginia.gov. Submitting this form is not a referral for care. Please call 804-864-7906 with any reporting questions. Please call your local health department about referral options for follow-up or treatment.