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.

Provider name: ______________________
Provider affiliation: ______________________
Provider telephone: ______________________
Provider email: ______________________

For Health Department use only: LTBI case status
☐ Confirmed ☐ Suspected TB Infection ☐ Not a case
LTBI case number (if known): ______________

☐ **Initial Report** ☐ **Follow-up Report**

Patient Information

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

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

Reporting Information and Risk factors

Name of reporting agency | **Date of initial LTBI evaluation**

Reporting agency type (*select one*)
☐ Correctional facility ☐ Long-term care facility
☐ Hospital ☐ Laboratory
☐ Military ☐ Private medical care provider
☐ Local health dept. ☐ Federally qualified health center
☐ School/daycare ☐ Other:______________

Reason for LTBI test (*select one*)
☐ Contact investigation
☐ Screening
☐ TB Symptoms
☐ Other:______________
☐ Unknown

HIV Status at diagnosis
☐ Negative
☐ Positive
☐ Unknown

Risk factors (*check all that apply*)
☐ Diabetes ☐ Homeless ☐ Heavy Alcohol Use ☐ Hepatitis ☐ End Stage Renal Disease ☐ Injecting drug use ☐ Noninjecting drug use
☐ Post-Organ Transplantation ☐ Immune modulating drugs (TNF-α therapy) ☐ Immunocompromised ☐ Congregate living situation
☐ Other: ______________________

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

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

Final evaluation outcome ☐ Latent TB infection ☐ Active TB ☐ Not TB/LTBI

Treatment

Was the patient offered LTBI treatment? ☐ Yes ☐ No

Did the patient start LTBI treatment? ☐ Yes ☐ No

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

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

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*)
☐ Treatment completed ☐ Pregnancy
☐ Active TB developed ☐ Provider decision
☐ Lost to follow-up ☐ Patient choice
☐ Adverse event ☐ Not LTBI
☐ Other: ______________________

Serious adverse event/reaction to LTBI treatment ☐ Hospitalization ☐ Death ☐ Other: ______________ ☐ None

Fax completed forms to ______________ at ______________ or send with encrypted email to ______________________. Please call ______________ with any questions.