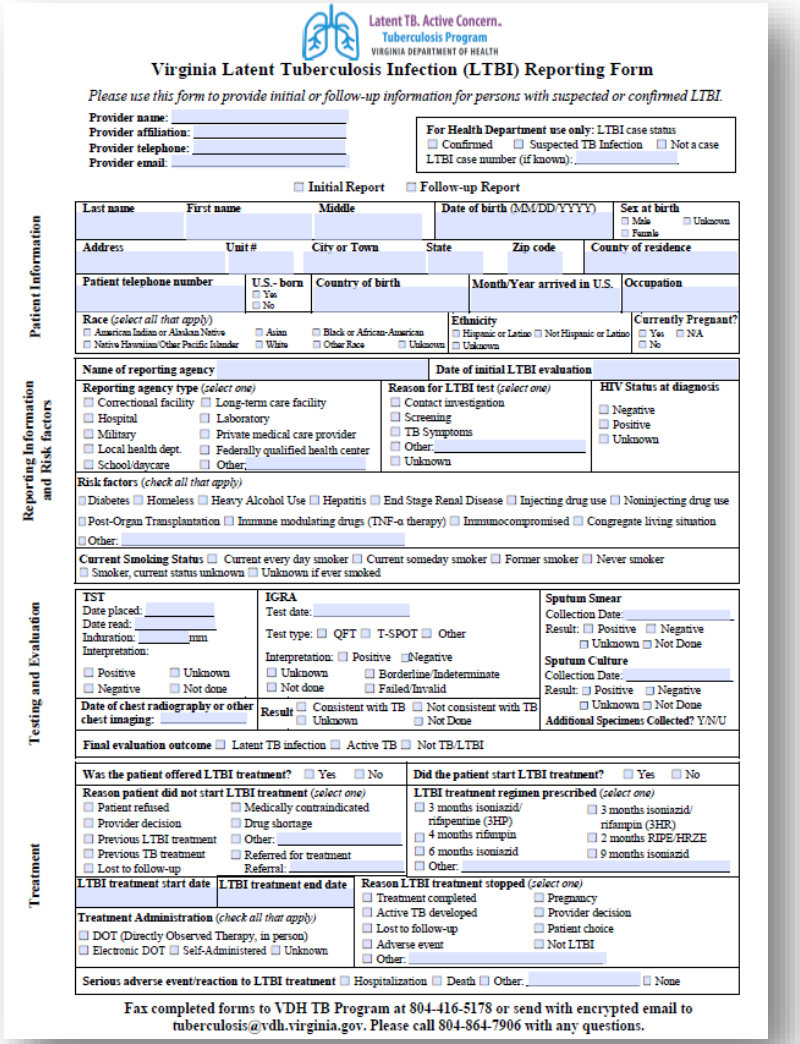
Where to enter data from the LTBI Reporting Form in LTBI investigations in VEDSS in the 2020 format



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

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 ☐ 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 ☐ No ☐ NA

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

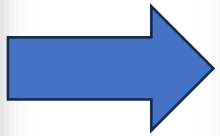
Testing and Evaluation

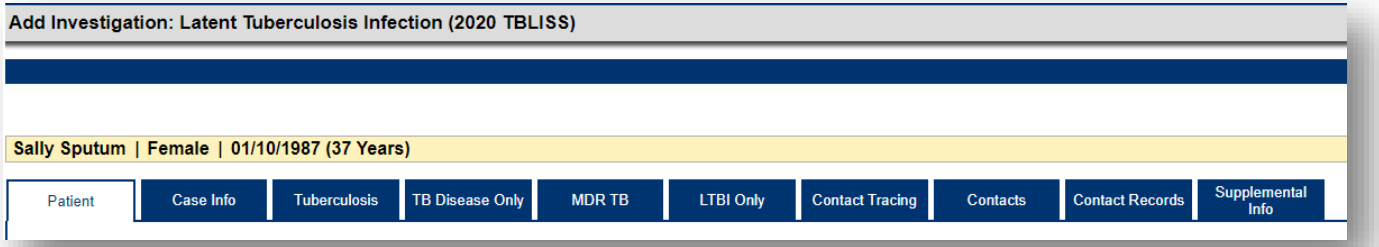
TST: Date placed: Date read: Induration: mm Interpretation: ☐ Positive ☐ Unknown ☐ Negative ☐ Not done
IGRA: Test date: Test type: ☐ QFT ☐ T-SPOT ☐ Other Interpretation: ☐ Positive ☐ Negative ☐ Unknown ☐ Borderline/Indeterminate ☐ Not done ☐ Failed/Invalid
Sputum Smear: Collection Date: Result: ☐ Positive ☐ 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
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:
Treatment Administration (*check all that apply*) ☐ DOT (Directly Observed Therapy, in person) ☐ Electronic DOT ☐ Self-Administered ☐ Unknown
Serious adverse event/reaction to LTBI treatment ☐ Hospitalization ☐ Death ☐ Other: ☐ None

Fax completed forms to VDH TB Program at 804-416-5178 or send with encrypted email to tuberculosis@vdh.virginia.gov. Please call 804-864-7906 with any questions.





January 2024

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

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: ____

Case Info Tab (Reporting Source Type and Reporting Organization)

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
				☐ Female

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

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

Race (*select all that apply*)
Patient Tab - Race

Ethnicity
Patient Tab - Ethnicity

Currently Pregnant?
Case Info – If female, was patient pregnant at d)

Patient Tab - Last Name, First Nam, Date of Birth, Current Sex, Sex at Birth

Patient Tab - Street Address 1, City, State, Zip, County

Tuberculosis Tab – Eligible for U.S. citizenship or nationality, Country of birth, country of birth, Date of first U.S. arrival, current occupation and industry

Reporting Information and Risk factors

Name of reporting agency — Case Info Tab - (Reporting Source Org)

Date of initial LTBI evaluation

Reporting agency type (*select one*)
Case Info Tab - (Reporting Source Type)

Reason for LTBI test (*select one*)
Tuberculosis Tab – Initial reason evaluated for TB

HIV Status at diagnosis
Tuberculosis Tab – HIV status

Risk factors (*check all that apply*)
☐ Diabetes ☐ Homeless ☐ Heavy Alc
☐ Post-Organ Transplantation ☐ Imm
☐ Other: ____
Tuberculosis Tab – "Other Risk Factors section"

Current Smoking Status ☐ Current
☐ Smoker, current status unknown ☐
Tuberculosis Tab – Current smoking status at diagnostic evaluation

Testing and Evaluation

TST	IGRA	Sputum Smear
Tuberculosis Tab – In diagnostic testing section		
Date of chest radiography or other	Result ☐ Consistent with TB ☐ Not consistent with TB	☐ Unknown ☐ Not Done
Tuberculosis Tab – In chest imaging section		Additional Specimens Collected? Y/N/U
Final evaluation outcome	Case Info Tab – Case status	

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
- ☐ 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)*

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

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

LTBI Only Tab

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