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| LATENT TUBERCULOSIS INFECTION (LTBI) EVALUATION FORM Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  First M.I. Last PASTE “C Label” HERE SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_ Health Dept. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Local Health Department Reporting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **Date TB Record Opened: \_\_\_\_**/**\_\_\_\_**/**\_\_\_\_\_\_** | | |
| PATIENT INFORMATION | | | | | |
| **MR#: S.S.#** - - **DOB: \_\_\_\_**/**\_\_\_\_**/**\_\_\_\_\_\_ Gender:** ❑ Male ❑ Female | | | | | |
| NAME: Last First MI | | | | | |
| Street/Apt #: | | City: | | State: \_\_\_\_ | Zip: |
| **Home Phone: County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Within City Limits** ❑ Yes ❑ No | | | | | |
| **DEMOGRAPHIC/EMPLOYMENT DATA** | | | | | |
| **Ethnicity:** ❑ Hispanic ❑ Non-Hispanic  **Race:** ❑ White ❑ Black/African American ❑ American Indian/Alaska Native  ❑ Asian (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Native Hawaiian/Pacific Islander (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Country of birth:** ❑ U.S. ❑ Other: Date arrived in US: **\_\_\_\_**/**\_\_\_\_**/**\_\_\_\_\_\_** | | | | | |
| **Employment:** ❑ Health Care Worker ❑ Retired ❑ Correctional Employee ❑ Not employed within Past 24 Months | | | | | |
| ❑ Migratory Agricultural Worker ❑ Other Occupation Employed at: | | | | | |
| REASON FOR TESTING (check one) | | | | | |
| ❑ Suspect ❑ Contact ❑ Converter ❑ Volunteer/walk-in ❑ Administrative (No Risk) ❑ Medical Risk ❑ Population Risk  **Patient originated from**: ❑ Health Department ❑ Referred by Private MD | | | | | |
| **MEDICAL / POPULATION RISK: (check all that apply)** | | | | | |
| **Medical Risks** | ❑ Chronic Renal Failure ❑ Leukemia, Lymphoma, Hodgkins ❑ Steroid ❑ NO MEDICAL RISK NOTED | | | | |
| ❑ Diabetic ❑ Chronic Malabsorption ❑ Transplant Recipient | | | | |
| ❑ Gastrectomy/jejunoileal bypass ❑ Silicosis ❑ Weight Loss >10%BW | | | | |
| ❑ Immunosuppressed ❑ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Population Risks** | ❑ Prison / Jail inmate **(circle below)**  **Federal Prison State Prison Local Jail Juvenile Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unknown** | | | | |
| ❑ Long-term Care Facility resident **(circle below)**  **Nursing Home Hosp Based Facility Residential Facility Mental Health Resident Alcohol/ Drug Facility** **Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unknown**  ❑ Homeless ❑ Foreign Born ❑ Health Care Worker ❑ Correctional Employee ❑ Injecting Drug User | | | | |
| **HIV Test Date: \_\_\_\_\_**/**\_\_\_\_\_**/**\_\_\_\_\_ HIV Status:** ❑ Positive ❑ Negative ❑ Refused ❑ Unknown **Based On:** ❑ Medical Documentation ❑ Patient History | | | | | |
| **Injecting drug use** ❑ Yes ❑ No ❑ Unk **Non-injecting drug use** ❑ Yes ❑ No ❑ Unk **Excess alcohol use** ❑ Yes ❑ No ❑ Unk | | | | | |
| **MANTOUX TUBERCULIN SKIN TEST (TST) or BLOOD ASSAY for *MYCOBACTERIUM TUBERCULOSIS* (BAMT / IGRA) & HISTORY** | | | | | |
| **(If no documentation of prior positive TST or positive BAMT/IGRA is available, use targeted testing for TST or BAMT/IGRA based on TB Risk Assessment)** | | | | | |
| **Documented Prior TST or BAMT/ IGRA:** Date / / TST Reading (mm): TST or BAMT/ IGRA Result**:** ❑ Positive ❑ Negative | | | | | |
| **Documented prior therapy for LTBI?** ❑ No ❑ Yes, Date: / / ❑ Unknown  **History:** ❑ No Hx of contact/no disease ❑ Exposed to TB/Contact ❑ Infected/TST positive or BAMT/IGRA positive | | | | | |
| **Current TSTs:** Date Given **\_\_\_\_\_**/**\_\_\_\_\_**/**\_\_\_\_\_** By Date Read **\_\_\_\_\_**/**\_\_\_\_\_**/**\_\_\_\_\_** By Reading (mm) ❑ Retest required | | | | | |
| Date Given **\_\_\_\_\_**/**\_\_\_\_\_**/**\_\_\_\_\_** By Date Read **\_\_\_\_\_**/**\_\_\_\_\_**/**\_\_\_\_\_** By Reading (mm) ❑ Retest required | | | | | |

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| PATIENT INFORMATION | | | | | | | | | | | | | |
| NAME: Last First DOB:    / / | | | | | | | | | | | | | |
| MANTOUX TUBERCULIN SKIN TEST (TST) or BLOOD ASSAY for *MYCOBACTERIUM TUBERCULOSIS* (BAMT / IGRA) & HISTORY (Continued) | | | | | | | | | | | | | |
| Current BAMTs / IGRAs: Date Drawn \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ BAMT/ IGRA Result: ❑ Positive ❑ Negative ❑ Indeterminate ❑ Borderline Brand of BAMT / IGRA Test ordered ❑ QuantiFERON-TB Gold Plus ❑ T-SPOT.*TB* Current BAMTs / IGRAs: Date Drawn \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ BAMT/ IGRA Result: ❑ Positive ❑ Negative ❑ Indeterminate ❑ Borderline  Brand of BAMT / IGRA Test ordered ❑ QuantiFERON-TB Gold Plus ❑ T-SPOT.*TB* | | | | | | | | | | | | | |
| CHEST X-RAY | | | | | | | | | | | | | |
| Date Taken | | | Normal | | | | Abnormal | | | Unknown | | | |
| **/ /** | | |  | | | |  | | |  | | | |
| **/ /** | | |  | | | |  | | |  | | | |
| **Liver Functions** (If needed: see TB Protocols in CCSG) Date Given **\_\_\_\_\_**/**\_\_\_\_\_**/**\_\_\_\_\_** ❑ Normal ❑ Abnormal | | | | | | | | | | | | | |
| DRUG REGIMEN – List drug(s) | | | | | | | | | | | | | |
| Drug | Dosage | Frequency | | Duration | Start Date | End Date | Drug | Dosage | Frequency | | Duration | Start Date | End Date |
|  |  |  | |  | / / | / / |  |  |  | |  | / / | / / |
|  |  |  | |  | / / | / / |  |  |  | |  | / / | / / |
| TREATMENT CLOSURE | | | | | | | | | | | | | |
| **Administration:** ❑ Directly observed LTBI therapy ❑ Totally self-administered ❑ Both directly observed and self-administered  **LTBI therapy site:** ❑ Clinic or other facility ❑ In the field ❑ Both in facility and in the field    **Health Care Provider**: ❑ Health Department ❑ Private/Other ❑ Both Health Department and Private/Other | | | | | | | | | | | | | |
| **Date treatment stopped:** // **Number of doses taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | |
| **Reason treatment stopped:** ❑ Adverse Drug Reaction ❑ MD chose to stop | | | | | | | | | | | | | |
| ❑ Completed ❑ Client moved (follow-up unknown) | | | | | | | | | | | | | |
| ❑ Died ❑ Refused | | | | | | | | | | | | | |
| ❑ Lost ❑ TB Disease developed (submit RVCT) | | | | | | | | | | | | | |
| ❑ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| The Latent Tuberculosis Infection Evaluation form is designed to collect information on all Latent Tuberculosis Infected persons who start treatment.  Mail to: Kentucky Department for Public Health, TB Prevention and Control Program, HS2E-B, 275 E. Main, Frankfort, KY 40621 or  Fax to: (502) 564-3772. | | | | | | | | | | | | | |