Latent Tuberculosis Infection (LTBI)
State of Nevada *Confidential Report Form*

Provider

Reporting Provider	Provider Phone	Provider Fax
Facility Name & Address	Provider Email	Date Reported

Please complete the below fields and check the boxes as completely as possible.

Patient

Patient Name		Date of Birth	Race ☐White ☐Black ☐Asian ☐Native American ☐ Pacific Islander ☐ Other: _____
Address		Gender at Birth ☐ Female ☐ Male	Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown
City	State	Zip	
Phone	Medical Record No.	Primary Language	
Country of Birth	Date Entry into U.S.	Experienced in past year ☐ Homelessness ☐ Incarceration	

Risk Factors/Reason

Risk Factors / Reason for Tuberculosis Screening *(check all that apply)*:

☐TB symptoms/signs; evaluating for TB disease

☐Close Contact to a person with active TB disease within past 2 years*

☐Non-U.S.-born *(excluding Australia, Canada, New Zealand, and Western Europe)*

☐Visit outside the U.S. > 1 month within past 5 years *(excluding Australia, Canada, New Zealand, and Western Europe)*

☐Immunosuppression, current or planned *(HIV infection, organ transplant recipient, treatment with αTNF antagonist, steroids)*

☐Co-morbidities which increase the risk of progression of LTBI to active TB disease: *diabetes, malignancy, pulmonary disease, silicosis, end-stage renal disease, intestinal bypass/gastrectomy, chronic malabsorption, body mass index ≤ 20*

☐Healthcare personnel TB screening

☐Resident or personnel in a congregate setting *(correctional facilities, homeless shelters, long-term care, home for individual residential care, inpatient substance abuse facilities)* TB screening

Diagnostics

☐ **IGRA (Blood) Test** (QuantiFERON/T-Spot) ☐ **Tuberculin Skin Test**	**Test Date**	**Result** ☐ Positive ☐ Negative ☐ Size (TST): _____mm	Was the Patient Provided Results ☐ Yes ☐ If *No*, Reason: _____
☐ **Chest X-Ray** (CXR)	**CXR Date**	**Result** ☐ Normal ☐ Abnormal	Was the Patient Provided Results ☐ Yes ☐ If *No*, Reason: _____

Treatment

Treatment Plan *(check one)*

☐ **Treatment (on-site).** (Patient has a planned LTBI therapy start date.); start date:_____

LTBI Treatment Regimen: (check one below)

☐ **12 weeks Isoniazid/Rifapentine (3HP)**

☐ **4 mo. Rifampin (4 RIF)** ☐ **3 mo. Isoniazid/RIF**

☐ **9 mo. Isoniazid (INH)** ☐ **6 mo. Isoniazid (INH)**

☐**Refer for Evaluation and Treatment**
Where Referred:

_____

Treatment Status:

☐ Completed

☐ Declined

☐ Other, *Reason*:

_____

*If the contact is suspected of exposure to multidrug-resistant TB, please contact your local health department or state Tuberculosis program for a treatment consultation.

Fax: ☐ **Completed Form** ☐ **IGRA Lab/TST** ☐ **Chest X-ray Report**

To: Carson City (775) 887-2138
Clark County (702) 759-1454
Washoe County (775) 328-3764
Rest of State (775) 684-5999

An optional assistance form is available: "LTBI Treatment Flowsheet: Dose, Symptom Monitoring, Completion"