WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

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	
City	State	Zip	
Phone	Medical Record No.	Primary Language	Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown
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	Washoe County	(775) 328-3764
Clark County	(702) 759-1454	Rest of State	(775) 684-5999

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