West Virginia Department of Health and Human Resources

Division of Tuberculosis Elimination

LATENT TUBERCULOSIS INFECTION RECORD

INITIAL REPORT _____ FINAL REPORT _____

LAST NAME: _____FIRST NAME: _____MI:_____ Birth Date: ____/____/_____ Age: _____

PHONE: (___) _____ ADDRESS: _____CITY:_____COUNTY:_____STATE:____ ZIP: _____

SEX	RACE	ETHNICITY	REASON FOR TESTING	RESIDENCE	COUNTRY OF BIRTH
_____MALE _____FEMALE	____WHITE ____ASIAN OR PACIFIC ISLANDER ____BLACK ____AMERCIAN INDIAN ____OTHER_____	____HISPANIC ____NON-HISPANIC ____UNKNOWN	SCREENING FOR: ___LOW RISK ___HIGH RISK ___WORK REQUIREMENT ___SYMPTOMS/DIAGNOSTIC ___CONTACT TO TB CASE ___MIGRANT WORKER ___IMMIGRANT/REFUGEE	___PRIVATE RESIDENCE ___HOMELESS ___SHELTER ___JAIL/PRISON ___NURSING HOME ___TREATMENT CENTER ___OTHER_____	___USA ___OTHER (SPECIFY) _____ IF OTHER, DATE OF ENTRY TO US: _____/_____/_____

DIABETES	CHEMICAL USE	HIV STATUS	LUNG DISEASE	GI/GU	CANCER/CHEMO	HEPATITIS	MEDICATIONS
____NONE KNOWN ____DIET ONLY ____ORAL MEDICINES ____INSULIN ____UNCONTROLLED	____NONE KNOWN ____INJECTED DRUG ABUSE ____OTHER DRUG ABUSE ____EXCESS ALCOHOL ____>2 DRINKS/DAY ____BINGE DRINKING ____CURRENT TOBACCO AMOUNT_____	____UNKNOWN ____NEGATIVE ____POSITIVE DATE:_____ TEST OFFERED: ____YES ____NO IF NO, REASON NOT OFFERED: _____	____NONE KNOWN ____ASTHMA ____SILICOSIS ____PNEUMONIA ____OTHER _____	____NONE KNOWN ____GASTRECTOMY ____WT.LOSS SURGERY ____RENAL DISEASE ____CIRRHOSIS ____PREGNANCY EDD:____/____/____ ____POST PARTUM	____NONE KNOWN ____LEUKEMIA ____LYMPHOMA ____OTHER MALIGNANCY ____IMMUNOSUPPESSIVE TX ____OTHER _____	____NONE KNOWN ____HEP A ____HEP B ____HEP C ____UNKNOWN TYPE	____NONE KNOWN ____STEROIDS ____TNF INHIBITORS ____ANTICONVULSANT ____TRANQUILIZER ____BIRTH CONTROL ____ANTICOAGULANT ____OTHER_____ ____ALLERGIES

PRIOR TB THERAPY	SYMPTOMS	SKIN TEST RESULTS	IGRA RESULTS	CHEST X-RAY
____NONE ____POST PREVENTIVE THERAPY (PT) ____PARTIAL PT ____UNDERGOING PT ____POST BCG, YEAR_____ ____MULTI-DRUG TX FOR ACTIVE TB YEAR_____	____NONE ____PRODUCTIVE COUGH ____HEMOPTYSIS ____SHORT OF BREATH ____WEIGHT LOSSS ____NIGHT SWEATS ____FEVER ____MALAISE ____CURRENT WT:_____ ____OTHER_____	TST #1 DATE:____/____/____ READING_____MM TST #2 DATE;____/____/____ READING_____MM KNOWN POSITIVE REACTOR _____MM YEAR;_____ LAST KNOWN NEGATIVE TEST DATE____/____/____	#1 TYPE _____ DATE:____/____/_____ ____POSITIVE ____NEGATIVE ____INDETERMINATE #2 TYPE _____ DATE:____/____/_____ ____POSITIVE ____NEGATIVE ____INDETERMINATE	DATE:_____/_____/_____ ____NORMAL ____WITHIN NORMAL LIMITS ____ABNORMALITY LIMITED TO CALCIFIED GRANULOMA(S) ____ABNORMAL ____POSSIBLE PRIMARY TB ____EVIDENCE OF OLD INACTIVE TB ____SUSPECT ACTIVE TB ____OTHER SEND ALL ABNORMAL CXR'S TO WVDTBE

REASONS FOR PREVENTIVE THERAPY	ANTI-TB DRUGS	DURATION	PREVENTIVE THERAPY	STOPPED PREVENTIVE THERAPY
____CONTACT, RECENT ____REACTOR ____CONVERTOR ____OLD TB DISEASE ____OTHER HIGH RISK _____	____ISONIAZID (INH) ____RIFAMPIN (RIF) ____RIFIPENTINE (RPT) ____OTHER _____	____2 MONTHS ____12 WEEKS ____4 MONTHS ____6 MONTHS ____9 MONTHS ____OTHER _____	START DATE:____/____/_____ STOP DATE____/____/____ MONTHS ON THERAPY_____ ____NOT RECOMMENDED ____REFUSED	____COMPLETED THERAPY ____LOST ____REFUSED ____DIED ____ACTIVE TB ____NOT INFECTED ____MOVED ____OTHER ____ADVERSE REACTION _____

CONTACT INVESTIGATION/INDEX CASE	REPORTING INFORMATION
LAST NAME_____ FIRST NAME_____ DOB_____/_____/_____ DATE TB DIAGNOSED_____/_____/_____ _____UNKNOWN INDEX CASE	PERSON REPORTING _____ FACILITY OR LOCAL HEALTH DEPARTMENT _____ DATE OF REPORT_____/_____/_____

COMMENTS: _____

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