

LATENT TUBERCULOSIS INFECTION RECORD

LAST NAME: _____ FIRST NAME: _____ MI: _____ Birth Date: ____/____/____ Age: _____

PHONE : (____) _____ ADDRESS: _____ CITY: _____ COUNTY: _____ STATE: _____

SEX	RACE	ETHNICITY	REASON FOR TESTING	RESIDENCE	COUNTRY OF BIRTH
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> WHITE <input type="checkbox"/> ASIAN OR PACIFIC ISLANDER <input type="checkbox"/> BLACK <input type="checkbox"/> AMERICAN INDIAN <input type="checkbox"/> OTHER _____	<input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC <input type="checkbox"/> UNKNOWN	SCREENING FOR: <input type="checkbox"/> LOWRISK <input type="checkbox"/> HIGHRISK <input type="checkbox"/> WORK REQUIREMENT <input type="checkbox"/> SYMPTOMS/DIAGNOSTIC <input type="checkbox"/> CONTACT TO TB CASE <input type="checkbox"/> MIGRANT WORKER <input type="checkbox"/> IMMIGRANT/REFUGEE	<input type="checkbox"/> PRIVATE RESIDENCE <input type="checkbox"/> HOMELESS <input type="checkbox"/> SHELTER <input type="checkbox"/> JAIL/PRISON <input type="checkbox"/> NURSING HOME <input type="checkbox"/> TREATMENT CENTER <input type="checkbox"/> OTHER _____	<input type="checkbox"/> USA <input type="checkbox"/> OTHER (SPECIFY) _____ IF OTHER, DATE OF ENTRY TO US: ____/____/____

DIABETES	CHEMICAL USE	HIV STATUS	LUNG DISEASE	GI/GU	CANCER/CHEMO	HEPATITIS	MEDICATIONS
<input type="checkbox"/> NONE KNOWN <input type="checkbox"/> DIET ONLY <input type="checkbox"/> ORAL MEDICATION <input type="checkbox"/> INSULIN <input type="checkbox"/> UNCONTROLLED	<input type="checkbox"/> NONE KNOWN <input type="checkbox"/> INJECTED DRUG USE <input type="checkbox"/> OTHER DRUG USE _____ <input type="checkbox"/> EXCESS ALCOHOL <input type="checkbox"/> >2 DRINKS/DAY <input type="checkbox"/> BINGE DRINKING <input type="checkbox"/> CURRENT TOBACCO AMOUNT _____	<input type="checkbox"/> UNKNOWN <input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE DATE: ____/____/____ TEST OFFERED: _____ <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, REASON NOT OFFERED: _____	<input type="checkbox"/> NONE KNOWN <input type="checkbox"/> ASTHMA <input type="checkbox"/> SILICOSIS <input type="checkbox"/> PNEUMONIA <input type="checkbox"/> OTHER _____	<input type="checkbox"/> NONE KNOWN <input type="checkbox"/> GASTRECTOMY <input type="checkbox"/> BYPASS SURGERY <input type="checkbox"/> RENAL DISEASE <input type="checkbox"/> PREGNANCY EDD: ____/____/____ <input type="checkbox"/> POST PARTUM	<input type="checkbox"/> NONE KNOWN <input type="checkbox"/> LEUKEMIA <input type="checkbox"/> LYMPHOMA <input type="checkbox"/> OTHER _____ <input type="checkbox"/> MALIGNANCY <input type="checkbox"/> IMMUNOSUPPRESSIVE TX <input type="checkbox"/> OTHER _____	<input type="checkbox"/> NONE KNOWN <input type="checkbox"/> HEP A <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> UNKNOWN TYPE	<input type="checkbox"/> NONE KNOWN <input type="checkbox"/> STEROIDS <input type="checkbox"/> TNF INHIBITORS <input type="checkbox"/> ANTICONVULSANT <input type="checkbox"/> TRANQUILIZER <input type="checkbox"/> BIRTH CONTROL <input type="checkbox"/> ANTICOAGULANT <input type="checkbox"/> OTHER _____ <input type="checkbox"/> ALLERGIES

PRIOR TB THERAPY	SYMPTOMS	SKIN TEST RESULTS	IGRA RESULTS	CHEST X-RAY
<input type="checkbox"/> NONE <input type="checkbox"/> POST PREVENTIVE THERAPY (PT) <input type="checkbox"/> PARTIAL PT <input type="checkbox"/> UNDERGOING PT <input type="checkbox"/> POST BCG, YEAR _____ <input type="checkbox"/> MULTI-DRUG TX FOR ACTIVE TB YEAR _____	<input type="checkbox"/> NONE <input type="checkbox"/> PRODUCTIVE COUGH <input type="checkbox"/> HEMOPTYSIS <input type="checkbox"/> SHORT OF BREATH <input type="checkbox"/> WEIGHT LOSS <input type="checkbox"/> NIGHT SWEATS <input type="checkbox"/> FEVER <input type="checkbox"/> MALAISE <input type="checkbox"/> CURRENT WT: _____ <input type="checkbox"/> OTHER _____	TST #1 DATE: ____/____/____ READING _____ MM TST #2 DATE: ____/____/____ READING _____ MM KNOWN POSITIVE REACTOR _____ MM YEAR; LAST KNOWN NEGATIVE TEST DATE ____/____/____	#1 TYPE _____ DATE: ____/____/____ <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE <input type="checkbox"/> INDETERMINATE #2 TYPE _____ DATE: ____/____/____ <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE <input type="checkbox"/> INDETERMINATE	DATE: ____/____/____ <input type="checkbox"/> NORMAL <input type="checkbox"/> WITHIN NORMAL LIMITS <input type="checkbox"/> ABNORMALITY LIMITED TO CALCIFIED GRANULOMA(S) <input type="checkbox"/> ABNORMAL <input type="checkbox"/> POSSIBLE PRIMARY TB <input type="checkbox"/> EVIDENCE OF OLD INACTIVE TB <input type="checkbox"/> SUSPECT ACTIVE TB <input type="checkbox"/> OTHER _____ SEND ALL ABNORMAL CXR'S TO WVDOTB

REASONS FOR PREVENTIVE THERAPY	ANTI-TB DRUGS	DURATION	PREVENTIVE THERAPY	STOPPED PREVENTIVE THERAPY
<input type="checkbox"/> CONTACT, RECENT REACTOR <input type="checkbox"/> CONVERTOR <input type="checkbox"/> OLD TB DISEASE <input type="checkbox"/> OTHER HIGH RISK	<input type="checkbox"/> ISONIAZID (INH) <input type="checkbox"/> RIFAMPIN (RIF) <input type="checkbox"/> RIFAPENTINE (RPT) <input type="checkbox"/> OTHER _____	<input type="checkbox"/> 2 MONTHS <input type="checkbox"/> 12 WEEKS <input type="checkbox"/> 4 MONTHS <input type="checkbox"/> 6 MONTHS <input type="checkbox"/> 9 MONTHS <input type="checkbox"/> OTHER _____	START DATE: ____/____/____ STOP DATE ____/____/____ MONTHS ON THERAPY _____ <input type="checkbox"/> NOT RECOMMENDED <input type="checkbox"/> REFUSED	<input type="checkbox"/> COMPLETED THERAPY <input type="checkbox"/> REFUSED <input type="checkbox"/> ACTIVE TB <input type="checkbox"/> MOVED <input type="checkbox"/> ADVERSE REACTION <input type="checkbox"/> LOST <input type="checkbox"/> DIED <input type="checkbox"/> NOT INFECTED <input type="checkbox"/> OTHER _____

CONTACT INVESTIGATION/INDEX CASE	REPORTING INFORMATION
LAST NAME _____ FIRST NAME _____ DOB ____/____/____ DATE TB DIAGNOSED ____/____/____ <input type="checkbox"/> UNKNOWN INDEX CASE	PERSON REPORTING _____ FACILITY OR LOCAL HEALTH DEPARTMENT _____ DATE OF REPORT ____/____/____

COMMENTS: _____

