

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



WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

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: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown
	Address		Gender at Birth ☐ Female ☐ Male	
	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 α TNF 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"**