PUBLIC HEALTH DIVISION
HIV-STD-TB Programs/Oregon TB Program

Oregon Health Authority

Treatment of Latent Tuberculosis Infection

LPHA or ODOC location:			
Name *(last)*:	*(first)*	*(M.I.)*	DOB:
Address:			Phone number:
Gender: ☐ Male ☐ Female	Race *(specify)*:	Hispanic: ☐ Yes ☐ No	Homeless in past year: ☐ Yes ☐ No

Country of origin: ☐ USA ☐ Other:________________________ Date arrived: _________________

EVALUATION

Tuberculin skin test:

Date: _________________ Result: ________________mm Interpretation: ☐ Positive ☐ Negative

IGRA (*QuantiFERON/T Spot*)**:** Date: _______________ Result: ___________________

Chest x-ray: Date: _________________ Results: ☐ Normal ☐ Abnormal-not active TB

Diagnosis: ☐ Latent TB infection ☐ Previous LTBI Tx *(date)*: _____________ ☐ Other:________________

Reason for testing *(risk factors)***:**

☐ Contact (*NOTE: This form is NOT needed for contacts to cases.*)

☐ Medical (*converter, HIV+, IVDU, diabetes, silicosis, chronic renal failure, gastrectomy, immunosuppressive therapy, etc.*)

☐ Population (*high prevalence country, incarcerated, health care facility, nursing home, homeless shelter, etc.*)

☐ No known risk factors

LTBI TREATMENT

Treatment start date: _________________

Regimen:

☐ Rifampin daily 4 months (*120 doses in 6 months*)

☐ INH and Rifapentine (*12 once weekly doses*)

☐ INH daily 9 months (*270 doses in 12 months*)

☐ INH daily 6 months (*180 doses in 9 months*)

☐ INH bi-weekly DOT 9 months *(76 doses in 12 months)*

☐ INH bi-weekly 6 months *(52 doses in 9 months)*

CLOSED

Date closed:_____________

Therapy: DOT ☐ Yes ☐ No
☐ Both, self and observed

Reason closed:

☐ Completed treatment

☐ Active TB diagnosed

☐ Died

☐ Moved: Transferred care to: _________________________

☐ Moved: Follow-up unknown

☐ Client stopped on own

☐ Lost to follow-up

☐ Provider decision: Toxicity

☐ Provider decision: Other: _________________________

When closed section is completed, fax 971-673-0178 or mail copy of this form to:

TB Program
800 NE Oregon Street, Suite 1105
Portland, Oregon 97232

Name: (*last*)	(*first*)	(*M.I.*)	DOB:	ID number:

MONTHLY MONITORING WHILE ON LTBI TREATMENT

Drugs issued:	Dose:	Date issued:	Amount issued mg tabs/ number per bottle:	Next appointment:	Fatigue	Nausea	Vomiting	Neuropathy	Dark urine	Jaundice	Abdominal pain	Easy bruising	Other	Symptoms of TB disease	Signature:
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