Oregon TB Control
DHS - Health Services

TREATMENT OF LATENT TUBERCULOSIS INFECTION

Name: ______________________________ **DOB:** ______________ **ID #:** ______________________
(Last) (First) (M.I.)
Address: ______________________________ **Phone:** ______________

County HD -or- ODOC Site:

Sex: ☐ Male ☐ Female
Race: ☐ White ☐ Black ☐ Amer. Indian ☐ Asian / Pacific Islander
Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Country of Origin: ☐ USA ☐ Other: ____________________
Date Arrived: ________________
Homeless in past year: ☐ Yes ☐ No

EVALUATION

Current Tuberculin Skin Test: Date: ________________ Result: __________ mm Interpretation: ☐ Positive ☐ Negative

Previous Tuberculin Skin Test: Date: ________________ Result: __________ mm Interpretation: ☐ Positive ☐ Negative

Chest X-Ray: Date: ______________ Results: ☐ Normal ☐ Abnormal-not active TB ☐ Asymptomatic

Diagnosis: ☐ Class II (TB infection-no disease) ☐ Class IV (Hx of TB-no current disease) ☐ Previous LTBI Tx (Date): ____________

Reason for Treatment - Risk Group (mark one):

☐ Administrative (from high prevalence country >5 years ago, routine screen from low risk facility, known reactor, etc.)
☐ Medical (Converter, HIV+, IVDU, <5 years old, diabetes, silicosis, chronic renal failure, gastrectomy, immunosuppressive therapy, etc.)
☐ Population (from high prevalence country < 5 years, residency in prison, jail, health care facility, nursing home, homeless shelter, etc.)
☐ Contact to an active case Name of index/source case: ______________________________ ☐ Window Period Treatment

PHYSICIAN INFORMATION

Name of Physician: ______________________________ Telephone: ______________________________

Address: ______________________________ Notified that patient has stopped treatment and reason (Date): ________________

TREATMENT

Regimen:
☐ INH daily 6 months (180 doses in 9 months)
☐ INH daily 9 months (270 doses in 12 months)
* ☐ INH bi-weekly DOT 6 months (52 doses in 9 months)
* ☐ INH bi-weekly DOT 9 months (76 doses in 12 months)
* ☐ INH+RIF daily DOT for 4 months (120 doses in 6 months)
* ☐ RIF daily DOT 4 months (120 doses in 6 months)
☐ Other ______________________

*** Use appropriate DOT form instead of section below**

Date Started on Treatment: __________________

Drug: ______________ Dose: ______________mg-qd

Drug: ______________ Dose: ______________mg-qd

☐ Pyridoxine (vitamin B6) Dose: ________________mg-qd

☐ **Patient advised of side effects (Date):** ________________

Drugs Issued	Date Issued	Amount Issued mg tabs / # per bottle	Next Appt.	Malaise	Anorexia	Nausea	Vomiting	Neuropath	Dark urine	Jaundice	Abd. pain			Signature
☐ INH ☐ B6														
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Date Closed: ____________________

Directly Observed Therapy
☐ No, all self-administered
☐ Yes, all directly observed
☐ Yes, both self and observed

Reason Closed:
☐ Completed treatment
☐ Active TB diagnosed
☐ Died
☐ Moved: transferred care*
☐ Moved: follow-up unknown
☐ Client stopped on own
☐ Lost to follow-up
☐ Provider decision: Toxicity
☐ Provider decision: Other*
*Specify: ______________________

When Closed Section is completed, mail a copy of the front side of this form to State TB Control)

FOR CLINIC USE ONLY

PATIENT INFORMATION

Cough	☐ Yes ☐ No	Date: ________
Sputum production	☐ Yes ☐ No	Date: ________
Hemoptysis	☐Yes ☐ No	Date: ________
Weight loss	☐ Yes ☐ No	Date: ________
Current weight	________	Date: ________
Previous weight	________	Date: ________
Dyspnea	☐ Yes ☐ No	Date: ________
"Cold" at present	☐ Yes ☐ No	Date: ________
Pregnant at present	☐ Yes ☐ No	Date: ________
Breast feeding	☐ Yes ☐ No	Date: ________

Diabetes:	☐ Yes ☐ No	Date: ________
Emphysema	☐ Yes ☐ No	Date: ________
Bronchitis	☐ Yes ☐ No	Date: ________
Pneumonia	☐ Yes ☐ No	Date: ________
Pleurisy	☐ Yes ☐ No	Date: ________
Hepatitis	☐ Yes ☐ No	Date: ________
Gastrectomy	☐ Yes ☐ No	Date: ________
Liver Disorder	☐ Yes ☐ No	Date: ________
BCG Vaccine	☐ Yes ☐ No	Date: ________

Other Medical Conditions: ____

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Smoking status: ☐ None ☐ Ex-smoker ☐ Smoke ________ pkg/day ________ years

Alcohol consumption (per day) ____

Medications:

Allergies: ____

☐ Dilantin
☐ Steriods
☐ Birth Control Pills
☐ Others (specify) ____

Comments: ____