Print Form

State of CT Department of Public Health
Tuberculosis Control Program
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LATENT INFECTION SURVEILLANCE REPORT FORM
COMPLETE FOR ALL TB INFECTIONS

PATIENT'S NAME: (LAST) | (FIRST) | SEX: ☐ M ☐ F | DATE OF BIRTH: MM DD YYYY

STREET ADDRESS: | CITY: | STATE: | ZIP: | HOME TELEPHONE:

SSN: | CONTACT TO KNOWN CASE? ☐ NO ☐ YES ☐ UNKNOWN | IF YES, NAME SOURCE CASE: | HISTORY OF BCG VACCINE AND DATE? ☐ YES ☐ NO ☐ UNKNOWN MM YYYY

RACE: ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN: SPECIFY_____ ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER: SPECIFY_____ | ETHNIC ORIGIN: ☐ HISPANIC ☐ NON-HISPANIC | COUNTRY OF BIRTH: | US ENTRY DATE: MM YYYY | IF NOT US, REFUGEE? ☐ NO ☐ YES

SCREENING

TUBERCULIN (MANTOUX) SKIN TEST:

DATE READ: MM DD YYYY

☐ POSITIVE _____ MILLIMETERS OF INDURATION
☐ NEGATIVE
☐ NOT DONE

INTERFERON GAMMA RELEASE ASSAY FOR MYCOBACTERIUM TUBERCULOSIS:

DATE COLLECTED: MM DD YYYY

☐ POSITIVE ☐ INDETERMINATE
☐ NEGATIVE ☐ NOT DONE

TEST TYPE: (SPECIFY) _____

HISTORY OF NEGATIVE PPD? ☐ YES ☐ NO | DATE OF LAST NEGATIVE PPD: MM YYYY | PREVIOUS TB? ☐ YES ☐ NO | IF YES, YEAR: | CLASSIFICATION OF PREVIOUS TB? ☐ DISEASE ☐ BOTH ☐ INFECTION | MORE THAN ONE PREVIOUS EPISODE OF DISEASE? ☐ YES ☐ NO

HIV STATUS (AS REQUIRED BY PUBLIC HEALTH CODE 19A-36-A7)

HIV TEST DATE: MM DD YYYY

HIV TEST RESULTS:
☐ NEGATIVE ☐ INDETERMINATE ☐ REFUSED
☐ POSITIVE ☐ TEST DONE, RESULTS PENDING ☐ NOT OFFERED

HIV STATUS BASED ON:
☐ MEDICAL DOCUMENTATION
☐ PATIENT HISTORY
☐ UNKNOWN

XRAY / CAT SCAN

INITIAL XRAY DATE: MM DD YYYY | INITIAL RESULTS: ☐ NORMAL ☐ ABNORMAL | IF ABNORMAL: ☐ NONCAVITARY- POSSIBLY CONSISTENT WITH OLD HEALED TB DISEASE ☐ NONCAVITARY, NOT CONSISTENT WITH TB DISEASE | COMPARISON CHEST RADIOGRAPH DATE: MM DD YYYY | COMPARATIVE RESULTS: ☐ NORMAL ☐ STABLE-OLD HEALED TB

OCCUPATION/SCHOOL

OCCUPATIONS IN PAST 24 MONTHS: (CHECK ALL THAT APPLY)
☐ HEALTH CARE WORKER ☐ NOT EMPLOYED
☐ CORRECTIONAL EMPLOYEE ☐ STUDENT
☐ MIGRATORY AGRICULTURAL WORKER ☐ UNKNOWN
☐ OTHER SPECIFY: _____

MOST RECENT EMPLOYER/SCHOOL NAME:

EMPLOYER/SCHOOL ADDRESS::

RISK FACTORS

WHEN DIAGNOSED WAS PATIENT IN CORRECTIONS? ☐ YES ☐ NO
IF YES, TYPE OF FACILITY:
☐ FEDERAL PRISON
☐ STATE PRISON
☐ LOCAL JAIL
☐ JUVENILE CORRECTIONAL FACILITY
☐ OTHER CORRECTIONAL FACILITY
☐ UNKNOWN

WHEN DIAGNOSED WAS PATIENT IN LONG-TERM CARE FACILITY? ☐ YES ☐ NO
IF YES, TYPE OF FACILITY:
☐ NURSING HOME
☐ HOSPITAL-BASED FACILITY
☐ RESIDENTIAL FACILITY
☐ ALCOHOL/DRUG TREATMENT FACILITY
☐ MENTAL HEALTH RESIDENTIAL FACILITY
☐ OTHER LONG-TERM CARE FACILITY
☐ UNKNOWN

WITHIN THE PAST YEAR HAS THE PATIENT?
BEEN HOMELESS? ☐ YES ☐ NO ☐ UNKNOWN
USED INJECTION DRUGS? ☐ YES ☐ NO ☐ UNKNOWN
USED NON-INJECTION DRUGS? ☐ YES ☐ NO ☐ UNKNOWN
USED EXCESS ALCOHOL? ☐ YES ☐ NO ☐ UNKNOWN

DOES PATIENT HAVE HEALTH INSURANCE? ☐ YES ☐ NO

ARE YOU REQUESTING FREE MEDICATION FROM THE TUBERCULOSIS PROGRAM? ☐ YES ☐ NO
***IF YES, PLEASE ATTACH A PRESCRIPTION**

TREATMENT

THERAPY START DATE: MM DD YYYY | EXPECTED THERAPY DURATION:

INITIAL REGIMEN:
☐ ISONIAZID _____ MG
☐ RIFAMPIN _____ MG
☐ PYRIDOXINE (B6) _____ MG
☐ OTHER _____ MG
☐ OTHER _____ MG

PROVIDER INFORMATION

PHYSICIAN FOR CONTINUING TB SUPERVISION:

FACILITY:

ADDRESS:

TELEPHONE: | FAX:

PERSON COMPLETING THIS REPORT: | TELEPHONE: | DATE OF THIS REPORT: MM DD YYYY

MAIL: WHITE TO STATE HEALTH DEPARTMENT, YELLOW TO LOCAL HEALTH DEPARTMENT, PINK TO PATIENT'S FILE