**DEPARTMENT OF HEALTH SERVICES**
Division of Public Health
F-02265 (01/2019)

**STATE OF WISCONSIN**
Wis. Admin. Code § DHS 145.04
Tuberculosis Program
608-261-6319

# LATENT TUBERCULOSIS INFECTION (LTBI) CONFIDENTIAL CASE REPORT

**Completion of this form is required**

Return this form to the local health department in which the client resides, or upload to WEDSS.

For a list of local health departments: https://www.dhs.wisconsin.gov/lh-depts/counties.htm

## PATIENT INFORMATION

| Patient Name (last, first, middle initial) | Date of Birth (mm/dd/yyyy) |
|---|---|
| | |

| Street Address | Telephone Number |
|---|---|
| | |

| City | Zip Code | County |
|---|---|---|
| | | |

Sex ☐ Male ☐ Female

Gender ☐ Transgender ☐ Female to male ☐ Male to female ☐ Unspecified/gender non-specific

**Race** ☐ Native American/Native Alaskan ☐ Asian *(specify)*: _____ ☐ White ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____ ☐ Unknown

**Ethnicity** ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown

History of positive TB test (TST or IGRA) or TB disease? ☐ Yes ☐ No

History of treatment for TB disease or infection? ☐ Yes ☐ No

## DIAGNOSTIC INFORMATION

**Mantoux test (TST)**
**Date Placed:** _____ **Date Read:** _____ Results (mm): _____ ☐ Positive ☐ Negative

**IGRA (Quantiferon/T-SPOT)**
**Date Collected:** _____ Numeric results or number of spots: Nil _____ Mitogen-Nil _____ TB1 Ag-Nil _____ TB2 Ag-Nil _____ Interpretation: ☐ Positive ☐ Indeterminate/borderline ☐ Negative ☐ Not done

**Chest Imaging** (Chest X-ray or CT)
**Date performed**: _____ Results: ☐ Abnormal ☐ Cavitary ☐ Miliary ☐ Normal ☐ Abnormal, not consistent with active TB

**Microbiologic**

| Date Collected | Source | AFB Smear | | PCR/NAAT | | Culture | |
|---|---|---|---|---|---|---|---|
| | | POS | NEG | POS | NEG | POS | NEG |
| | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**HIV status at the time of diagnosis**

☐ Negative ☐ Positive ☐ Indeterminate ☐ Refused ☐ Not Offered ☐ Unknown

**Patient Signs and Symptoms**

**Date of Onset**: _____ ☐ Fever, chills, and/or night sweats ☐ Productive cough >3 weeks

☐ None ☐ Hemoptysis (coughing up blood) ☐ Unexplained weight loss

**REASON FOR TESTING AND FOLLOWUP**

☐ **Birth, travel, or residence** in a country with high TB prevalence.

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.
- Travel is of extended duration or including likely contact with infectious TB in a location of high TB prevalence.
- IGRA is preferred over TST for foreign-born persons 2 years of age or older.

☐ **Close** (high priority) **contact** to someone with infectious TB disease during lifetime.

☐ **Recent** TB symptoms: Persistent cough lasting three or more weeks **AND** one or more of the following symptoms: coughing up blood, fever, chills, night sweats, unexplained weight loss, or fatigue.

☐ **Current** or former employee or resident of a high-risk, congregate setting in a state or district with an elevated TB rate.

- Includes Alaska, California, Florida, Hawaii, New Jersey, New York, Texas, or Washington DC.
- Includes correctional facility, long-term residential care facility, or shelter for the homeless.

☐ Due to start immunosuppressant/immunomodulation therapy for treatment
Therapy or treatment:

_____

☐ Employee or volunteer or admission to:
☐ Health care facility ☐ School ☐ Day care ☐ Other: _____

Additional Information (optional)

| Name of Provider (Print) | Assessment Date |
|---|---|
| Facility Name | Phone Number |
| Street Address | City, State, Zip code |

**SIGNATURE** - Provider Date Signed

**Reset/Clear Entire Form**