

Maryland Latent Tuberculosis Infection (LTBI) Reporting Form

Provider name: _____
Provider affiliation: _____
Provider telephone: _____

For Health Department use only: LTBI case status
 Confirmed Suspected TB Infection Not a case
 LTBI case number (if known): _____

Initial Report Follow-up Report

Last name	First name	Middle	Date of birth (MM/DD/YYYY)	Sex at birth <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female		
Address		Unit #	City or Town	State	Zip code	County of residence
Patient telephone number		U.S.- born <input type="checkbox"/> Yes <input type="checkbox"/> No	Country of birth		Month/Year arrived in U.S.	
Race (select all that apply) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other Race <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		

Reporting Information and Risk factors

Name of reporting agency: _____		Date of first LTBI evaluation: _____	
Reporting agency type select one <input type="checkbox"/> Employment <input type="checkbox"/> Long-term care facility <input type="checkbox"/> Correctional facility <input type="checkbox"/> Immigrant/refugee clinic <input type="checkbox"/> Military <input type="checkbox"/> Private medical care provider <input type="checkbox"/> Local health dept. <input type="checkbox"/> Federally qualified health center <input type="checkbox"/> School/daycare <input type="checkbox"/> Other: _____		Reason for LTBI test select one <input type="checkbox"/> Healthcare worker <input type="checkbox"/> Testing to rule out TB <input type="checkbox"/> School/education screening <input type="checkbox"/> Employment/administrative test <input type="checkbox"/> B-waiver <input type="checkbox"/> Refugee screen (non B-waiver) <input type="checkbox"/> Contact investigation. Contact number, if known: _____ <input type="checkbox"/> Other: _____	
HIV status at diagnosis <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Unknown		Risk factors check all that apply <input type="checkbox"/> Diabetes <input type="checkbox"/> End-stage renal disease <input type="checkbox"/> Congregate living situation <input type="checkbox"/> Smoking <input type="checkbox"/> Homeless within past year <input type="checkbox"/> Immune modulating drugs <input type="checkbox"/> Hepatitis <input type="checkbox"/> Injection drug user <input type="checkbox"/> Pregnancy <input type="checkbox"/> Alcohol <input type="checkbox"/> Non-injection drug use <input type="checkbox"/> Other: _____	

Testing and Evaluation

TST Agency: _____ Date read: _____ Interpretation: <input type="checkbox"/> Positive <input type="checkbox"/> Unknown <input type="checkbox"/> Negative <input type="checkbox"/> Not done	IGRA Test date: _____ Test type: <input type="checkbox"/> QFT <input type="checkbox"/> T-SPOT <input type="checkbox"/> Other Interpretation: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Borderline/Indeterminate <input type="checkbox"/> Not done <input type="checkbox"/> Failed/Invalid	Smear Collection Date: _____ Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Not done Culture Collection Date: _____ Result Date: _____ Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Not done
Date of chest radiography or other chest imaging: _____	Chest radiography or chest imaging result: <input type="checkbox"/> Consistent with TB <input type="checkbox"/> Not consistent with TB <input type="checkbox"/> Unknown <input type="checkbox"/> Not done	
Final evaluation outcome: <input type="checkbox"/> Latent TB infection/no TB <input type="checkbox"/> Active TB, RVCT case number (if known): _____		

Treatment

Was the patient offered LTBI treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the patient start LTBI treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason patient did not start LTBI treatment: <input type="checkbox"/> Refused <input type="checkbox"/> Referred for treatment <input type="checkbox"/> Provider decision Referral: _____ <input type="checkbox"/> Previous LTBI treatment <input type="checkbox"/> Previous TB treatment <input type="checkbox"/> Lost to follow-up	LTBI treatment regimen prescribed: <input type="checkbox"/> 9 months Isoniazid <input type="checkbox"/> 4 months Rifampin <input type="checkbox"/> 12 weeks Isoniazid/Rifapentine <input type="checkbox"/> Other: _____
LTBI treatment start date: _____	Reason LTBI treatment stopped: <input type="checkbox"/> Treatment completed <input type="checkbox"/> Pregnancy <input type="checkbox"/> Active TB developed <input type="checkbox"/> Provider decision <input type="checkbox"/> Lost to care <input type="checkbox"/> Patient moved <input type="checkbox"/> Adverse event <input type="checkbox"/> Died <input type="checkbox"/> Other: _____
LTBI treatment end date: _____	Serious adverse event/reaction to LTBI treatment: <input type="checkbox"/> Hospitalization <input type="checkbox"/> Death <input type="checkbox"/> Other: _____ <input type="checkbox"/> None

Maryland Latent Tuberculosis Infection (LTBI) Reporting Form Instructions

Demographic Information

- **Sex at birth:** The biological sex of the patient at birth per patient report
- **U.S.-born:**
 - **Yes:** The patient was born in 1 of the 50 states or the District of Columbia, or born to a parent who is a US citizen.
 - **No:** The patient was born abroad.
- **Country of birth:** Enter the name of the country in which the person was born. Fill this out for all patients (including U.S. born patients).
- **Month/Year arrived in U.S.:** When the patient first arrived in the United States (1 of the 50 states or the District of Columbia)
- **Race (select all that apply):** Per patient report
- **Ethnicity (please check one):**
 - **Hispanic or Latino:** Patient considers himself or herself Cuban, Mexican, Puerto Rican, south or Central American, or of other Spanish culture or origin, regardless of race.
 - **Not Hispanic:** Patient does not consider himself or herself to be Hispanic or Latino
 - **Unknown:** Patient's ethnicity is not known.

Reporting and Risk Factors

- **Name of reporting agency:** Name of the agency that is reporting the LTBI case (e.g. Johns Hopkins Medical Institutions, Anne Arundel County Department of Health)
- **Date of first LTBI evaluation:** Month, day, and year that the patient was evaluated for LTBI.
- **Reporting agency type (Please check one):**
 - **Employment:** Occupational health
 - **Correctional facility:** Jail, prison, or detention facility
 - **Military:** Military or military-affiliated health facility (e.g. Baltimore Veteran Affairs Medical Center, 79th Medical Wing at Andrews Air Force Base)
 - **Local health dept.:** For example, Howard County Health Department
 - **School/daycare:** Educational facility such as a Pre-school, K-12, College, University
 - **Long-term care facility:** Nursing home, rehabilitation facility, etc.
 - **Immigrant/refugee clinic:** Clinic that specializes in treating immigrants and/or refugees
 - **Private medical care provider:** A non-public healthcare provider (e.g. Johns Hopkins Medical Institutions, private medical practices). This includes acute care facilities.
 - **Federally qualified health center (FQHC):** Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations.
 - **Other:** If the appropriate reporting agency type is not listed, please write it here.
- **Reason for LTBI test (Please check one):**
 - **Healthcare worker:** Anyone working in a healthcare setting (e.g. hospital, ambulatory care, acute care, long-term care facilities)

- **School/education screening:** A student who must be tested for school or other educational opportunity
- **B-waiver:** Individuals with certain visas who are medically screened overseas, considered high-risk for TB, and require further evaluation upon entry to the U.S.
- **Contact investigation:** Patient has had contact, within the last 2 years, with a person known to have an active TB infection. **Contact number if known:** If the contact number is known, please write it in the provided space. Notify LHD.
- **Testing to rule out/in TB:** Patient requires testing because he or she is suspected of having active TB disease.
- **Employment/administrative test:** An employee who must be tested before receiving clearance to return to work or begin working. If healthcare worker then select healthcare worker even for employment testing.
- **Refugee screen (non B-waiver):** A refugee who requires testing but does not have a B-waiver.
- **Other:** If the appropriate reason is not already listed, please write it here.
- **HIV status at diagnosis (Please check one):** Per patient report.
 - **Negative**
 - **Positive**
 - **Unknown**
- **Risk factors (Please check all that apply):**
 - **Diabetes:** Patient has a diagnosis, including self-report, of diabetes mellitus (Type I or Type II) either before or at the time of LTBI diagnosis.
 - **Smoking:** Patient is currently a regular smoker or has quit within the last 12 months.
 - **Hepatitis:** Patient has a diagnosis, including self-report, of hepatitis (any type) either before or at the time of LTBI diagnosis.
 - **Alcohol:** Patient has used alcohol to excess within the past 12 months.
 - **End-stage renal disease:** Patient has end-stage renal disease or chronic renal failure at the time of TB diagnosis.
 - **Homeless within past year:** A person who has no home (e.g. is not paying rent, does not own a home, and is not steadily living with relatives or friends). Persons in unstable housing situations (e.g. alternating between multiple residences for short stays of uncertain duration) may also be considered homeless.
 - **Injection drug user:** Patient has used injection drugs within the past 12 months.
 - **Non-injection drug user:** Patient has used non-injection drugs within the past 12 months.
 - **Congregate living situations:** Communal living facilities in which many people share a residence (e.g. correctional facilities, long-term care facilities, long-term drug and alcohol treatment facilities, orphanages, shelters).
 - **Immune modulating drugs:** For example, steroids, TNF inhibitors or related drugs, chemotherapy, or anti-rejection drugs for organ transplant.
 - **Other:** Please write any additional risk factor(s).

Testing and Evaluation

- **TST:** Tuberculin skin test
 - **Agency:** Name of the agency that placed the test
 - **Date read:** Month, day, and year the TST was read
 - **Interpretation (Please check one):**

- **Positive:** Meets the criteria for a positive TST result, results reported in mm.
 - **Negative:** Results of TST did not meet current criteria for a positive test result
 - **Not done:** TST was not performed.
 - **Unknown:** It is not known whether a TST was performed or result is not known for a reason other than pending results.
- **IGRA:** Interferon gamma release assay
 - **Test date:** Month, day, and year the blood sample was collected
 - **Test type (Please check one):**
 - **QFT:** QuantiFERON test
 - **T-SPOT:** T-SPOT TB test
 - **Interpretation (Please check one):** Results as reported by the laboratory
 - **Positive:** As reported by laboratory
 - **Negative:** As reported by laboratory
 - **Borderline/Intermediate:** As reported by laboratory
 - **Unknown:** IGRA result is not known
 - **Not done:** IGRA was not performed
- **Chest radiography or other chest imaging (Please check one):**
 - **Consistent with TB:** Chest radiograph showed abnormalities (e.g., hilar adenopathy, effusion, infiltrate[s], cavity, scarring) consistent with TB. If TB is suspected contact LHD.
 - **Not consistent with TB:** Chest radiograph showed no abnormalities consistent with TB. This category includes no abnormalities noted or any abnormalities that are not consistent with TB.
 - **Unknown:** It is not known whether a chest radiograph was done, or the result of the chest radiograph is not known, or the result is not known for a reason other than pending results.
 - **Not done:** A chest radiograph was not done.
- **Date of chest earliest radiography or other chest imaging:** If there are multiple, please fill in the date of the “diagnostic” radiograph.
- **Final evaluation outcome:** Please check one.
 - **Latent TB infection/no TB:** Symptoms, lab results, and radiography are consistent with the presence of a latent tuberculosis infection (LTBI) and no tuberculosis disease at all.
 - **Active TB, RVCT case number (if known):** Symptoms, lab results, and radiography are consistent with the presence of active tuberculosis disease. Please provide the Report of Verified Case of Tuberculosis (RVCT) case number if known. If active TB is suspected please contact local health department.

Treatment

- **Was the patient offered LTBI treatment?** Did a healthcare provider communicate an offer of treatment to the patient?
- **Did the patient start LTBI treatment?** Did the patient accept the offer of treatment and begin the prescribed regimen?
- **Reason patient did not start LTBI treatment (Please check one):**
 - **Refused:** Patient declined to start LTBI treatment.
 - **Provider decision:** Provider decided that treatment was not appropriate.

- **Previous LTBI treatment:** Patient has already been treated for LTBI.
- **Previous TB treatment:** Patient has already been treated for TB.
- **Lost to follow-up:** Contact with patient was lost.
- **LTBI treatment regimen prescribed (Please check one):** Do not include vitamin B6.
- **LTBI treatment start date:** Month, day, and year the patient began drug therapy for LTBI.
- **LTBI treatment end date:** Month, day, and year the patient stopped drug therapy (whether due to completion, adverse event, pregnancy, or other reason).
- **Reason LTBI treatment stopped:**
 - **Treatment completed:** Patient completed the prescribed course of therapy per the medical record as recorded by the physician caring for the patient.
 - **Active TB developed:** Patient developed active TB during treatment for LTBI.
 - **Lost to care:** Contact with patient was lost.
 - **Adverse event:** Patient had an adverse reaction to treatment that necessitated the termination of treatment.
 - **Pregnancy:** Patient needed to stop treatment due to pregnancy.
 - **Provider decision:** Physician decided to stop treatment.
 - **Patient moved:** Patient changed to a different jurisdiction.
 - **Died:** Patient died.
- **Serious adverse event/reaction to LTBI treatment:**
 - **Hospitalization:** Patient required hospitalization as result of a condition caused by LTBI treatment.
 - **Death:** Patient died due to LTBI treatment.
 - **Other:** Please fill in any other serious event that occurred as a result of taking LTBI treatment. This includes any systemic or life threatening condition, such as Steven-Johnson syndrome.
 - **No serious adverse event:** Patient did not have a serious adverse event or reaction caused by LTBI treatment.