INTERJURISDICTIONAL TUBERCULOSIS NOTIFICATION FOR LTBI

IDPH Illinois Department of Public Health

REFERRING JURISDICTION:		**Date Sent:**
Contact Person:	Phone:	Fax:
City:	County:	State:

LTBI: ❒ Reactor ❒ Converter

Indication for Screening:

❒Medical Condition ❒ Foreign Born ❒ Employee Screening ❒ Recent Contact of Infectious TB Case ❒ Homeless

❒Migrant Worker ❒Nursing Home Resident ❒Correctional Facility Inmate ❒Drug Treatment Facility Resident

Patient Name: _____ Gender: ❒ M ❒ F

AKA: _____

Date of Birth: _____/_____/_____ Interpreter Needed? ❒ No ❒ Yes, specify language _____

New Address: _____ Hispanic: ❒ No ❒ Yes

City/State/Zip Code: _____ Race: ❒ White ❒ Black ❒ Asian

New Telephone ( ) _____ ❒ Am. Indian/Nat. Alaskan

Date of Expected Arrival to New Jurisdiction: ____/____/____ ❒ Other: _____

Patient's Country of Origin: ❒ United States ❒ Other: _____

New Health Provider: ❒ Unknown ❒ Known (name, address, phone) _____

Emergency Contact: Name _____ Phone: ( ) _____

Relationship: _____

Screening Results:

TB Skin Test Date: _____/_____/_____ Result: _____mm ❒ Test Not Done

IGRA Date: _____/_____/_____ Result: ❒ Positive ❒ Negative ❒ Indeterminate ❒ Borderline ❒ Test Not Done

CXR or CT Date: _____/_____/_____ Result: ❒ Normal ❒ Abnormal, Not Consistent with Active TB ❒ Other: _____

Medications/Treatments

Treatment Start Date: _____/_____/_____ ❒ Treatment Not Started **Adherence Problems/Side Effects:**

Medication:

ISONIAZID	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
RIFAMPIN	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
PYRIDOXINE	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
_____	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
_____	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____

Treatment End Date: _____/_____/_____

Comments:

_____

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