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 ☐ Male ☐ Unknown ☐ Female
Address Unit # City or Town State Zip code	County of residence	
Patient telephone number	U.S.- born ☐ Yes ☐ No	Country of birth	Month/Year arrived in U.S.

Race (select all that apply)
☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other Race ☐ Unknown

Ethnicity
☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Unknown

Reporting Information and Risk factors

Name of reporting agency:

Date of first LTBI evaluation:

Reporting agency type *select one*
☐ Employment ☐ Long-term care facility
☐ Correctional facility ☐ Immigrant/refugee clinic
☐ Military ☐ Private medical care provider
☐ Local health dept. ☐ Federally qualified health center
☐ School/daycare ☐ Other: _____________________

Reason for LTBI test *select one*
☐ Healthcare worker ☐ Testing to rule out TB
☐ School/education screening ☐ Employment/administrative test
☐ B-waiver ☐ Refugee screen (non B-waiver)
☐ Contact investigation. Contact number, if known: ____ ☐ Other: ____________________

HIV status at diagnosis
☐ Negative
☐ Positive
☐ Unknown

Risk factors *check all that apply*
☐ Diabetes ☐ End-stage renal disease ☐ Congregate living situation
☐ Smoking ☐ Homeless within past year ☐ Immune modulating drugs
☐ Hepatitis ☐ Injection drug user ☐ Pregnancy
☐ Alcohol ☐ Non-injection drug use ☐ Other: _______________

Testing and Evaluation

TST
Agency: _________________
Date read: ________________
Interpretation:
☐ Positive ☐ Unknown
☐ Negative ☐ Not done

IGRA
Test date: _________________
Test type: ☐ QFT ☐ T-SPOT ☐ Other
Interpretation: ☐ Positive ☐ Negative
☐ Unknown ☐ Borderline/Indeterminate
☐ Not done ☐ Failed/Invalid

Smear Collection Date:___________
Result: ☐ Positive ☐ Negative
☐ Unknown ☐ Not done
Culture Collection Date: _________
Result Date: _____________
Result: ☐ Positive ☐ Negative
☐ Unknown ☐ Not done

Date of chest radiography or other chest imaging: ______

Chest radiography or chest imaging result: ☐ Consistent with TB ☐ Not consistent with TB ☐ Unknown ☐ Not done

Final evaluation outcome: ☐ Latent TB infection/no TB ☐ Active TB, RVCT case number (if known): ____________________

Treatment

Was the patient offered LTBI treatment? ☐ Yes ☐ No

Did the patient start LTBI treatment? ☐ Yes ☐ No

Reason patient did not start LTBI treatment:
☐ Refused ☐ Referred for treatment
☐ Provider decision Referral: _______________
☐ Previous LTBI treatment
☐ Previous TB treatment
☐ Lost to follow-up

LTBI treatment regimen prescribed:
☐ 9 months Isoniazid
☐ 4 months Rifampin
☐ 12 weeks Isoniazid/Rifapentine
☐ Other: ____

LTBI treatment start date:

LTBI treatment end date:

Reason LTBI treatment stopped:
☐ Treatment completed ☐ Pregnancy
☐ Active TB developed ☐ Provider decision
☐ Lost to care ☐ Patient moved
☐ Adverse event ☐ Died
☐ Other: ____

Serious adverse event/reaction to LTBI treatment: ☐ Hospitalization ☐ Death ☐ Other: _________________ ☐ 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 <u>not</u> 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 <u>read</u>
    - **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.