DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44125 (Rev. 01/2019)

STATE OF WISCONSIN
608-261-6319

LATENT TUBERCULOSIS INFECTION (LTBI) FOLLOW-UP REPORT

Return the completed form when the client completes a recommended course of therapy or discontinues treatment.

Local Health Department – Name and Address

Return to:

The Local Health Department in which patient resides.

Or upload to WEDSS

For information, contact the
Wisconsin TB Program 608-261-6319

Client Name (last, first, middle initial)	Date of Birth (mm/dd/yyyy)

Client Address (street, city, zip code)

Latent Tuberculosis Determination *(check all that apply)*

☐ **IGRA (Quantiferon or TSPOT) interpretation**
☐ positive ☐ negative ☐ indeterminate
☐ borderline

☐ **Tuberculin Skin Test Interpretation**
☐ positive ☐ negative

☐ **Chest Imaging results**
☐ consistent with TB ☐ not consistent with TB

☐ ***Mycobacterium tuberculosis* complex (MTBC) culture results**
☐ MTBC detected ☐ MTBC not detected

Latent Tuberculosis Treatment

Medication	Medication start date	Medication stop date	Completed according to CDC criteria?
☐ Isoniazid			☐ Yes ☐ No
☐ Rifampin			☐ Yes ☐ No
☐ Isoniazid and rifapentine (3HP)			☐ Yes ☐ No
☐ Other _____			☐ Yes ☐ No

Disposition

Did patient complete an adequate treatment regimen? ☐ Yes ☐ No
If No, select reason:

☐ Death
☐ Patient moved (follow-up unknown)
☐ Active TB developed
☐ Adverse effect of medicine
☐ Patient chose to stop
☐ Patient is lost to follow-up
☐ Provider decision

Service Provider

Name of Provider (Print) — Assessment Date

Facility Name — Phone Number

Street Address — City, State, Zip code

SIGNATURE - Provider — Date Signed

Clear / Rest Entire Form