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Rev. 8/2006

**Massachusetts Department of Public Health**
**Bureau of Communicable Disease Control**
**Office of Integrated Surveillance and Informatics Services**
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Received in Surveillance: ☐☐ / ☐☐ / ☐☐☐☐

# Latent Tuberculosis Infection (LTBI) Reporting Form

*Confidential Case Report*

**Last Name:**

**First Name:**

**Address:**

**DOB:** *(mm/dd/yyyy)* ☐☐ / ☐☐ / ☐☐☐☐

**Sex:** M ☐ F ☐

**City:**

**State:** ☐☐ **Zip:** ☐☐☐☐☐

**Phone Number:** ( ☐☐☐ ) ☐☐☐ - ☐☐☐☐

**Country of Birth:**

U.S. ☐ Other: ☐ *Specify Other:*

**Date of entry into US:** *(mm/dd/yyyy)* ☐☐ / ☐☐ / ☐☐☐☐

## Diagnostic Information

**Mantoux test (TST) administered:** *(mm/dd/yyyy)* ☐☐ / ☐☐ / ☐☐☐☐

**Results (mm):** ☐☐

**QuantiFERON Result:**
☐ Positive ☐ Indeterminate
☐ Negative ☐ Not Done

**Date:** *(mm/dd/yyyy)* ☐☐ / ☐☐ / ☐☐☐☐

**% Response:** ☐☐☐

## Risk & Treatment Information

**Risk Factors:**

- ☐ Close Contact to a person with active TB disease within the past 2 years — *Source Name*
- ☐ Child 4 years of age or under
- ☐ Recent arrival (within past 5 years) from TB endemic country
- ☐ Medical risks for progressing to active TB disease:
- ☐ Health care worker
- ☐ Mycobacteria laboratory worker
- ☐ Resident of high risk congregate setting

**Treatment Plan:**

☐ Not treat —> If not why: ☐ Pregnant ☐ Prev. Tx. ☐ ABN ALT ☐ Other — *Specify Other:*

☐ Treat (On-Site)

☐ Refer for evaluation (where):

**Reporting Provider:** *(Last Name, First Name)*

**Date Completed:** *(mm/dd/yyyy)* ☐☐ / ☐☐ / ☐☐☐☐

**Facility/Agency:**

**Phone Number:** ( ☐☐☐ ) ☐☐☐ - ☐☐☐☐

**Make solid marks that fit in the response boxes. Please use black or blue ink.**

**Right way ->** A B **Wrong way ->** A B

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