1. *To be completed by Civil Surgeons*

* Complete if patient has a **positive IGRA** and ruled out for active TB
* Please attach the results of both the IGRA and CXR and complete the section below

Dear ,

I am referring (DOB: ) to your care for the treatment of **latent tuberculosis infection** (LTBI). I evaluated the patient as part of immigration screening requirements. I am referring the patient to you because the patient had a **positive IGRA** and was ruled out for active/infectious TB. To prevent TB disease from developing, **treatment** for LTBI is recommended in most patients. See cdph.ca.gov/ltbitreatment for more information.

Below and attached please find a summary of the patient’s evaluation. **When the patient completes treatment or has another outcome, please fax this form to the local health department TB program (see CTCA.org for contact info).**

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| **Chest x-ray result:** | 🞏normal 🞏 abnormal, not consistent with TB (see report attached) |
| **Interferon-gamma release assay:** see report attached  Additional comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
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Signature/Civil Surgeon Name Phone number E-mail Date

1. *To be completed by Receiving Provider:*

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| LTBI Treatment |  |
| * Date started treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Date completed treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_   with the following regimen:   * Isoniazid/Rifapentine (3 months; 3HP) * Rifampin (4 months; 4R) * Isoniazid (9 months; 9H) * Isoniazid (6 months; 6H) * Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | If patient did ***not*** start treatment, primary reason why:   * Lost to follow-up * Treatment medically contraindicated * Patient refused * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   If patient started but did ***not***complete treatment, primary reason why:   * Patient chose to stop * Provider chose to stop * Pregnancy * Patient moved * Lost to follow-up * Active TB developed * Adverse event related to treatment * Patient died * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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Signature/Provider Name Phone number E-mail Date