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).**

|  |  |
| --- | --- |
| **Chest x-ray result:** | 🞏normal 🞏 abnormal, not consistent with TB (see report attached) |
| **Interferon-gamma release assay:** see report attachedAdditional comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ |

 Signature/Civil Surgeon Name Phone number E-mail Date

1. *To be completed by Receiving Provider:*

|  |  |
| --- | --- |
| 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