DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-02265 (01/2019)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 145.04
Tuberculosis Program
608-261-6319

LATENT TUBERCULOSIS INFECTION (LTBI) CONFIDENTIAL CASE REPORT

Completion of this form is required

Return this form to the local health department in which the client resides, or upload to WEDSS.

For a list of local health departments: https://www.dhs.wisconsin.gov/lh-depts/counties.htm

PATIENT INFORMATION

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

Street Address | Telephone Number

City | Zip Code | County

Sex: ☐ Male ☐ Female

Gender: ☐ Transgender ☐ Female to male ☐ Male to female ☐ Unspecified/gender non-specific

Race ☐ Native American/Native Alaskan ☐ Asian *(specify)*: __________ ☐ White ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other: _______________ ☐ Unknown

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown

History of positive TB test (TST or IGRA) or TB disease? ☐ Yes ☐ No

History of treatment for TB disease or infection? ☐ Yes ☐ No

DIAGNOSTIC INFORMATION

Mantoux test (TST)
Date Placed: ____________ **Date Read:** ____________ Results (mm): ______ ☐ Positive ☐ Negative

IGRA (Quantiferon/T-SPOT)
Date Collected: __________
Numeric results or number of spots: Nil _____ Mitogen-Nil _____ TB1 Ag-Nil _____ TB2 Ag-Nil _____
Interpretation: ☐ Positive ☐ Indeterminate/borderline ☐ Negative ☐ Not done

Chest Imaging (Chest X-ray or CT)
Date performed: __________
Results: ☐ Abnormal ☐ Miliary ☐ Normal ☐ Cavitary ☐ Abnormal, not consistent with active TB

Microbiologic

Date Collected	Source	AFB Smear		PCR/NAAT		Culture	
		POS	NEG	POS	NEG	POS	NEG
		☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐

HIV status at the time of diagnosis

☐ Negative ☐ Positive ☐ Indeterminate ☐ Refused ☐ Not Offered ☐ Unknown

Patient Signs and Symptoms

Date of Onset: _____________ ☐ Fever, chills, and/or night sweats ☐ Productive cough >3 weeks

☐ None ☐ Hemoptysis (coughing up blood) ☐ Unexplained weight loss

REASON FOR TESTING AND FOLLOWUP

☐ **Birth, travel, or residence** in a country with high TB prevalence.

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.
- Travel is of extended duration or including likely contact with infectious TB in a location of high TB prevalence.
- IGRA is preferred over TST for foreign-born persons 2 years of age or older.

☐ **Close** (high priority) **contact** to someone with infectious TB disease during lifetime.

☐ **Recent** TB symptoms: Persistent cough lasting three or more weeks **AND** one or more of the following symptoms: coughing up blood, fever, chills, night sweats, unexplained weight loss, or fatigue.

☐ **Current** or former employee or resident of a high-risk, congregate setting in a state or district with an elevated TB rate.

- Includes Alaska, California, Florida, Hawaii, New Jersey, New York, Texas, or Washington DC.
- Includes correctional facility, long-term residential care facility, or shelter for the homeless.

☐ Due to start immunosuppressant/immunomodulation therapy for treatment
Therapy or treatment: ____

☐ Employee or volunteer or admission to:
☐ Health care facility ☐ School ☐ Day care ☐ Other:

Additional Information (optional)

Name of Provider (Print)	Assessment Date
Facility Name	Phone Number
Street Address	City, State, Zip code

SIGNATURE - Provider Date Signed