Dear Parent or Guardian,

Your student received testing for tuberculosis (TB) using a skin tuberculin test (TST) as part of a contact investigation conducted by the Flathead City-County Health Department. The results of this test were “reactive”. Based on this result, we are recommending that your student for further examination and diagnostic testing for TB with their primary care provider.

***Please note that your student is not currently experiencing any symptoms of TB, while this requires follow-up, it is not an emergency.***

To ensure the physician receives all the applicable information to this investigation, we have attached a document with testing results and follow-up recommendations. Please provide this document to your physician.

If you do not have a primary care physician, or are concerned about costs, you can contact the Flathead Community Health Center. Appointments with a physician will be available and services will be provided on a sliding fee scale. Appointments can be made by calling PHONE NUMBER.

If you have any additional questions, please contact the Flathead City-County Health Department at PHONE NUMBER.

Sincerely,

**Tuberculosis Contact Provider Letter**

|  |
| --- |
| **PATIENT NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

The patient (named above) has been identified by the Flathead City-County Health Department as a close contact of a person who has been diagnosed with active tuberculosis (TB). As part of the contact investigation a skin tuberculin test (TST) was conducted. The results are provided below:

|  |
| --- |
| Date TST Administered\_\_\_\_\_\_\_\_\_\_ Date TST Read\_\_\_\_\_\_\_\_\_\_\_TST Reading (in mm)\_\_\_\_\_\_\_\_\_\_\_\_ Test Location\_\_\_\_\_\_\_\_\_\_\_\_\_ |

For contacts whose test reaction induration diameter is >5 mm undergoing further examination and diagnostic testing for TB is recommended. Based on the patient’s TST results we are recommending the following:

⎕ Interferon gamma-release assay (IGRA) – for results 5-6mm\*

⎕ Chest radiograph – for results >6mm\*\*

*\*A positive blood test indicates that a chest radiograph must occur.*

*\*\*Asymptomatic contacts with normal chest radiograph findings should be regarded to have a recent tuberculosis infection, and be offered treatment.*

**Please fax all test results to the**

**Flathead City-County Health Department at FAX NUMBER.**

**Public Health Nurse:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If you have questions, please call LOCAL Health Department at PHONE NUMBER.*