

# DPHHS LATENT TB INFECTION (LTBI) TREATMENT PROGRAM

## \*Payer of Last Resort\*

Department of Public Health & Human Service  
TB Program  
Cogswell Building, Room C-216  
1400 Broadway, Helena, MT 59620  
Phone: 406-444-0275; Fax: 406-444-0272

Today's date: \_\_\_\_\_  
Submitted by: \_\_\_\_\_  
Agency: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Local Health Department:** Please mail or fax a copy of this form along with the prescription(s) to the TB Program to initiate treatment and mail or fax the completed form again upon completion or termination of treatment.

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Attending Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Public Health Manager: \_\_\_\_\_ Allergies: NKA  List allergies: \_\_\_\_\_

Does the patient have insurance: Yes  No  Does the patient have Medicaid: Yes  No

1. **Reason for TB Testing:**  Contact of known TB case; Name of case \_\_\_\_\_  
 Foreign born; Country of origin \_\_\_\_\_  
 Occupational \_\_\_\_\_  
 Other \_\_\_\_\_

2. **Tuberculin Skin Test/ IGRA (QFT or T-Spot) Result:**  
Signs/Symptoms consistent with active disease: Yes  No  TST Date: \_\_\_\_\_ QFT Date: \_\_\_\_\_  
Induration in mm: \_\_\_\_\_ Quantitative result: \_\_\_\_\_ Positive  Negative   
Health-care person placing/reading: \_\_\_\_\_ Lab: \_\_\_\_\_

3. **X-ray:**  
Date: \_\_\_\_\_ Where was it done? \_\_\_\_\_  
Result: \_\_\_\_\_

4. **Bacteriological Status:** (Smear or culture results if collected)  
Smear: Date: \_\_\_\_\_ Result: \_\_\_\_\_  
Culture: Date: \_\_\_\_\_ Result: \_\_\_\_\_

5. **Latent TB Infection Therapy:**  
Start date: \_\_\_\_\_  
Treatment regimen:  INH, 9 mo;  INH, 6 mo;  RIF, 4 mo;  INH/RIFAPENTINE (Must use DOT)

**When patient completes or otherwise ends treatment of LTBI fill out this section and mail or fax the entire form to the TB Program at DPHHS**

Treatment completion date: \_\_\_\_\_  
If treatment is not completed, discontinued date: \_\_\_\_\_

If discontinued, reason:  
 Diagnosed with active TB  Noncompliant  
 Medical suspension due to adverse reaction  Lost to follow up  
 Moved, records referred to:  Death

By signing below, I certify that to the best of my knowledge the patient above does not have other means to pay for medication or that the deductible is too great a financial burden for the patient to bare.

Submitted by: \_\_\_\_\_ Agency: \_\_\_\_\_ Today's Date: \_\_\_\_\_