

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: 406-444-0274; Fax: 800-616-7460

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, 12 week

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: _____