RHODE ISLAND DEPARTMENT OF HEALTH
DIVISION OF INFECTIOUS DISEASE AND EPIDEMIOLOGY
TUBERCULOSIS PROGRAM, 3 Capitol Hill, Room 106, Providence, RI 02908
TEL: (401) 222-2577 FAX: (401) 222-2478

# LATENT TUBERCULOSIS INFECTION (LTBI) COMPLETION OF THERAPY REPORT

Mail or fax completed report immediately upon completion or discontinuation of LTBI therapy.

## DEMOGRAPHICS

**Last Name:** | **First Name:**

**Street/Apt:**

**City:**

**DOB (mm/dd/yyyy):** _____ /_____/_____

**State/Zip:** | **Phone:**

**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

**Race: (select one or more)**
☐ American Indian or Alaska Native
☐ Asian: (specify)_____
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander: (specify)_____
☐ White

**Country of Birth:**
☐ US
☐ Not U.S.: (specify)_____

**Month-Year arrived in U.S.: (mm/yyyy)** _____/_____

**Sex:** ☐ Male ☐ Female

**Is the patient a contact to an active TB case?** ☐ Yes ☐ No
**If yes, name index case, if known:** _____

## TREATMENT FOR LTBI

☐ **COMPLETED**

**Date Started: (mm/dd/yyyy)** _____ /_____ /_____ **Date Completed: (mm/dd/yyyy)** _____ /_____ /_____

**Drug and Duration**
☐ Isoniazid, Daily for 6 months
☐ Isoniazid, Daily for 9 months
☐ Rifampin, Daily for 4 months
☐ Other (specify) Drug: _____ Duration _____

**Provide number of doses, if known** _____

☐ **NOT COMPLETED**

**Check reason for non completion:**

☐ Non-adherent
☐ Lost to follow-up
☐ Side effects (specify) _____
☐ Moved to _____
☐ Other (specify) _____

## COMMENTS

## REPORTING INFORMATION

**Reported by:** | **Telephone number of reporter:**

**Physician caring for patient:** | **Telephone number of physician:**

**Reporting facility:** | **Date of report:** _____ /_____ /_____