Montana LTBI Report Form

For Data Collection of Latent TB Infection (LTBI) Cases

*Questions in blue and with two ** before the question will be filled out by the state TB Program. If you have questions while filling out this form, contact your local health department, or the state at 444-0273.*

Patient Tab

1. **First Name**_____**Last Name:**_____**MIDIS ID**_____

2. **Date of Birth**: _____

3. **Sex at Birth**
   ___ Male
   ___ Female
      If Female, Was Patient Pregnant at Time of Diagnostic Evaluation?
      ___ Yes
      ___ No
      ___ Unknown
   ___ Unknown

4. **Patient Address**
   a. Address:_____
   b. City: _____ ZIP Code:_____
   c. County/Jurisdiction: _____

   **(State Use) Census Tract (11-digit GEOID): ☐☐☐☐☐☐☐☐☐☐☐

5. **Ethnicity**
   ___ Hispanic or Latino
   ___ Not Hispanic or Latino
   ___ Unknown

6. **Race**
   ___ American Indian or Alaska Native
   ___ Asian
   ___ Black or African American
   ___ Native Hawaiian or Other Pacific Islander
   ___ White
   ___ Other Race
   ___ Unknown

7. **Nativity**
   a. Country of Birth if NOT U.S.: _____
      (If NOT United States, Date of First U.S. Arrival:_____)
      i. If Country of Birth NOT U.S., Was the Patient Eligible for U.S. Citizenship/Nationality at Birth?
         ___ Yes
         ___ No
         ___ Unknown
   b. Countries of Birth for Primary Guardian(s) (pediatric [<15 years old] cases only)
      i. Guardian 1: _____
      ii. Guardian 2: _____

8. Country of Usual Residence

c. Country of Usual Residence: _____

d. If **NOT** U.S. Reporting Area, Has Been in United States for ≥90 days (inclusive of Report Date)?

___ Yes
___ No
___ Unknown

Case Information Tab

9. Earliest Date Reported to State:_____**County:**_____

10. **(State Use) State Case Number: ☐☐☐☐-☐☐-☐☐☐☐☐☐☐☐

11. **(State Use) Case Already Counted by Another Reporting Area?

___ Yes, another U.S. reporting area (State case number from other area:

☐☐☐☐-☐☐-☐☐☐☐☐☐☐☐)

___ Yes, another country (Specify country: _____)
___ No

12. **(State Use) Case Meets Binational Reporting Criteria?

___ Yes

If Yes, Which Criteria were Met? (Select All That Apply)

___ Exposure to Suspected Product from Canada or Mexico (e.g., dairy product for *M. bovis* case)
___ Has Case Contacts in or From Mexico or Canada
___ Potentially Exposed by a Resident of Mexico or Canada
___ Potentially Exposed while in Mexico or Canada
___ Resident of Canada or Mexico
___ Other Situations that May Require Binational Notification or Coordination of Response

___ No
___ Unknown

13. **(State Use) Complete Table Below for All Known TB and LTBI Cases Epidemiologically Linked to this Case

(an unlimited number of rows may be entered):

State Case Numbers: _____

14. Date Counted

a. MMWR Week:_____

b. MMWR Year:_____

15. Lost to Follow Up

___ Yes
___ No
___ Unknown

16. Control Measures Implemented

___ Yes
___ No
___ Unknown

Risk Factors Tab

17. Initial Reason Evaluated for TB

___ Contact Investigation
___ Screening
___ TB Symptoms
___ Other
___ Unknown

18. Case Previously Identified During the Contact Investigation Around Another Active TB Case?

___ Yes
If Yes, Evaluated for TB During that Contact Investigation?
___ Yes
___ No
___ Unknown
___ No
___ Unknown

19. Occupation and Industry

a. Has the patient *ever* worked as one of the following? (select all that apply)
___ Healthcare Worker
___ Correctional Facility Employee
___ Migrant/Seasonal Worker
___ Unknown

b. Patient's Current Occupation(s) and Industry(ies)

Occupation (E.g. Clerk / Preschool Teacher)	Industry (E.g. Supermarket / Childcare)

20. Residence Risk Factors

Risk Factor	Indicator
Homeless in the Past 12 Months	___Yes ___No ___ Unknown
Homeless Ever	___Yes ___No ___ Unknown
Resident of Correctional Facility at Diagnostic Evaluation	___Yes ___No ___ Unknown
Resident of Correctional Facility Ever	___Yes ___No ___ Unknown
Resident of Long-Term Care Facility at Diagnostic Evaluation	___Yes ___No ___ Unknown

21. If Resident of Correctional Facility at Diagnostic Evaluation, Type of Facility?

___ Federal Prison
___ State Prison
___ Local Jail
___ Juvenile Correction Facility
___ Other Correctional Facility
___ Unknown

22. If Resident of Long-Term Care Facility at Diagnostic Evaluation, Type of Facility?

___Nursing Home
___Hospital-Based Facility
___Residential Facility
___Mental Health Residential Facility
___Alcohol or Drug Treatment Facility
___Other Long-Term Care Facility
___Unknown

23. Substance Use Risk Factors

Risk Factor	Indicator
Injecting Drug Use in the Past 12 Months	___Yes ___No ___ Unknown
Noninjecting Drug Use in the Past 12 Months	___Yes ___No ___ Unknown
Heavy Alcohol Use in the Past 12 Months	___Yes ___No ___ Unknown

24. Current Smoking Status at Diagnostic Evaluation

(Includes consumption of tobacco or nicotine, through combustible products or electronic nicotine delivery systems)

___ Current everyday smoker
___ Current someday smoker
___ Former smoker
___ Never smoker
___ Smoker, current status unknown
___ Unknown if ever smoked

25. Immunosuppression Risk Factors

Risk Factor	Indicator
Diabetic at Diagnostic Evaluation	___Yes ___No ___ Unknown
TNF-α Antagonist Therapy	___Yes ___No ___ Unknown
Post-Organ Transplantation	___Yes ___No ___ Unknown
End Stage Renal Disease	___Yes ___No ___ Unknown
Viral Hepatitis (B or C only)	___Yes ___No ___ Unknown
HIV Status at Diagnosis	___Positive ___Negative ___Other ___ Unknown
Other Immunocompromise (other than HIV/AIDS)	___Yes ___No ___ Unknown
Other (Specify: _____)	___Yes ___No ___ Unknown

26. Lived outside of the United States for >2 months (uninterrupted)?

___Yes
___No
___Unknown

Diagnostic Testing Tab

27. Tuberculin Skin Test and All Non-DST TB Laboratory Test Results

Please provide a response for each of the main test types (culture, smear, pathology/cytology, NAA, TST, IGRA) If test was not done please indicate so. See list example in table.

Test Type	Specimen Source Site	Date Collected/ Placed	Date Reported/ Read	Test Result (Qual.)	Test Result (Quant.)	Test Result (Units of Measure)
E.g. TST	*Skin Structure*	*01/01/2020*	*01/03/2020*	*Positive*	*15*	*mm*
E.g. IGRA-QFT	*Blood*	*01/01/2020*	*01/05/2020*	*Positive*	*N/A*	*N/A*

Test Type Options: Smear, Pathology, Cytology, NAA, Culture, TST, IGRA-QFT, IGRA-TSpot, IGRA-Unknown, IGRA-Other, Other Test Type, and Pathology/Cytology
Specimen Source Options: Examples: Skin Structure, Blood, Sputum
Test Result (Qualitative) Options: Positive, Negative, Indeterminate, Not Done, Unknown, Refused, Test Done Result Unknown
Test Result (Units of Measure) Options: Examples: Millimeters of Induration (TST)

28. Chest Radiograph or Other Chest Imaging Study Results

(Please provide a response for each of the main test types (plain chest radiograph, chest CT Scan) and if test was not done please indicate so. *See list example in table.*)

Study Type	Date of Study	Result	Cavity?	Miliary?
Plain Chest X-Ray				
CT Scan				

Study Type Options: Plain Chest X-Ray, CT Scan, MRI, PET, Other
Result Options: Not Consistent with TB, Consistent with TB, Not Done, Unknown
Cavity Options: Yes, No, Unknown
Miliary Options: Yes, No, Unknown

Treatment Tab

29. LTBI Therapy Started?

___ Yes (Treatment Start Date: _____)
Specify Initial LTBI Regimen:
___ Isoniazid (9 months; 9H)
___ Isoniazid (6 months; 6H)
___ Isoniazid/Rifapentine (3 months; 3HP)
___ Rifampin (4 months; 4R)
___ Other (Specify: _____)
___ No
Why Not?
___ Lost to follow up
___ History of previous treatment for TB or LTBI
___ Treatment medically contraindicated
___ Treatment not offered based on local clinic guidelines
___ Provider decision (not based on local clinic guidelines)
___ Drug shortage
___ Patient refused
___ Other (Specify: _____)
___ Unknown

If Therapy Not Started or Unknown, STOP HERE.
If Therapy was Started, Continue to Question 30

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30. Date Therapy Stopped: _____

31. Treatment Administration (select all that apply)
___ DOT (Directly Observed Therapy, in person if elected)
___ EDOT (Electronic DOT, via video call or other electronic method if elected)
___ Self-Administered

32. Reason LTBI Therapy Stopped?
___ Completed Treatment
___ Lost to Follow-up
___ Patient Choice
___ Pregnancy
___ Not LTBI (Clinician Decision)
___ Other (Specify: _____)
___ Developed TB (** State Use, NTSS State Case Number:
☐☐☐☐-☐☐-☐☐☐☐☐☐☐☐☐)
___ Severe Adverse Event (select all that apply)
___ Hospitalized
___ Died

(PLEASE IMMEDIATELY REPORT ALL ADVERSE EVENTS RESULTING IN HOSPITALIZATION OR DEATH TO THE STATE TB PROGRAM AT 444-0273)