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
☐ Medical suspension due to adverse reaction
☐ Moved, records referred to:
_____
☐ Noncompliant
☐ Lost to follow up
☐ 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: _____