Tuberculosis Control Program

Patient Information Sheet for Treatment of Latent Tuberculosis Infection

For patients receiving preventative therapy with Isoniazid or Rifampin, the Department of Public Health requests the following data for epidemiological purposes. Please complete this form and return in the enclosed postage paid envelope or fax it to 515-281-4570. Thank you.

Date: ___________________________ M. Patricia Quinlisk, M.D.
Name: ___________________________ State Epidemiologist and Medical Director
Sex: M    F
Address: ___________________________ Phone: (____)____________________
City: ___________________________ Zip: ___________________________ County: ___________________________
Date of birth: ___________________________
Mantoux skin test date: _______________ Results: ___________ mm
*Results should be read and recorded in mm of induration only and should not include area of erythema.

Chest x-ray date (Please include chest x-ray report with fax) _______________
Normal______ Abnormal____________________________

Has TB disease been ruled out? Yes____ No____

Diagnosis: Latent Tuberculosis Infection: Yes____ No____
Planned course of treatment: INH 300 mg qd x: 9 months_____ 6 months_____ Other: _______________

Pyridoxine (Vit. B6): 25 mg qd x 6months_____ or 9 months_____ (Available for medical conditions in which neuropathy is common – diabetes, uremia, alcoholism, malnutrition, HIV infection, pregnancy).

Suspected TB Disease/Confirmed TB Disease
Please report all suspected cases of TB disease by phone:
Nurse Consultant – 515-281-8636 or Program Manager – 515-281-7504

Physician: ___________________________ Phone: (____)____________________
Address: ___________________________
City: ___________________________ Zip: ___________________________
Person making referral: ___________________________ Phone: (____)____________________

Please send medication to (circle one): County Public Health Department
OR
Physician’s Office