

## Referral for Latent Tuberculosis Infection Treatment

**To be completed by Civil Surgeon:**

To: \_\_\_\_\_

I evaluated \_\_\_\_\_ (DOB: \_\_\_\_\_) as part of the immigration screening requirements. I am referring the patient to you for treatment of latent tuberculosis infection treatment (LTBI) because the patient had a **positive IGRA** and was ruled out for active/infectious TB. To prevent TB disease from developing, **treatment** for LTBI is recommended in most patients.

Additional comments: \_\_\_\_\_

Attached please find a summary of the patient's evaluation. When the patient completes treatment or has another outcome, please fax this form to the Los Angeles County TB Control Program **(213) 749-0926**.

Civil Surgeon Name (Printed):	
Civil Surgeon Signature:	
Date:	
Phone Number:	
E-mail:	
Civil Surgeon Office Address:	

### LTBI Treatment Referral Outcome (Civil Surgeon)

**To be completed by Receiving Provider:**

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Date started LTBI Treatment: \_\_\_\_\_

Date completed LTBI Treatment: \_\_\_\_\_

**Regimen Used:**

- Isoniazid/Rifapentine (3 months; 3HP)
- Rifampin (4 months; 4R)
- Isoniazid (9 months; 9H)
- Isoniazid (6 months; 6H)
- Other: \_\_\_\_\_

If patient did **not** start treatment, primary reason why:

- Lost to follow-up
- Treatment medically contraindicated
- Patient refused
- Other: \_\_\_\_\_

If patient started but did **not** complete treatment, primary reason why:

- Patient chose to stop
- Provider chose to stop
- Pregnancy
- Patient moved
- Lost to follow-up
- Active TB developed
- Adverse event related to treatment
- Patient died
- Other: \_\_\_\_\_

Attached please find a summary of the patient's evaluation. When the patient completes treatment or has another outcome, please fax this form to the Los Angeles County TB Control Program **(213) 749-0926**.

Provider Name (Printed):	
Provider Signature:	
Date:	
Phone Number:	
E-mail:	
Provider Office Address:	