

Referral for Latent Tuberculosis Infection Treatment



1) To be completed by Civil Surgeons

- Complete if patient has a **positive IGRA** and ruled out for active TB
- Please attach the results of both the IGRA and CXR and complete the section below

Dear _____,

I am referring _____ (DOB: _____) to your care for the treatment of **latent tuberculosis infection (LTBI)**. I evaluated the patient as part of immigration screening requirements. I am referring the patient to you 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. See cdph.ca.gov/ltbitreatment for more information.

Below and 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 program (see below).**

Chest x-ray result: ☐ normal ☐ abnormal, not consistent with TB (see report attached)

Interferon-gamma release assay: see report attached

Additional comments: _____

Signature/Civil Surgeon Name

Phone number

E-mail

Date

2) To be completed by Receiving Provider:

LTBI Treatment

<input type="checkbox"/> Date started treatment: _____	If patient did not start treatment, primary reason why: <ul style="list-style-type: none"><input type="radio"/> Lost to follow-up<input type="radio"/> Treatment medically contraindicated<input type="radio"/> Patient refused<input type="radio"/> Other: _____
<input type="checkbox"/> Date completed treatment: _____ with the following regimen: <ul style="list-style-type: none"><input type="checkbox"/> Isoniazid/Rifapentine (3 months; 3HP)<input type="checkbox"/> Rifampin (4 months; 4R)<input type="checkbox"/> Isoniazid (9 months; 9H)<input type="checkbox"/> Isoniazid (6 months; 6H)<input type="checkbox"/> Other: _____	If patient started but did not complete treatment, primary reason why: <ul style="list-style-type: none"><input type="radio"/> Patient chose to stop<input type="radio"/> Provider chose to stop<input type="radio"/> Pregnancy<input type="radio"/> Patient moved<input type="radio"/> Lost to follow-up<input type="radio"/> Active TB developed<input type="radio"/> Adverse event related to treatment<input type="radio"/> Patient died<input type="radio"/> Other: _____

Signature/Provider Name

Phone number

E-mail

Date

Fax to the Los Angeles County TB program once complete
(213) 749-0926