LATENT TB INFECTION (LTBI) – MEDICINE ENROLLMENT
STATE PROVIDED MEDICINE APPLICATION

Today's Date: _____

Department of Public Health & Human Services
TB Program
Cogswell Building, Room C-216
1400 Broadway, Helena, MT 59620
Phone: 406-444-0275; Fax: 406-444-0272

Submitted By: _____

Agency: _____

Phone: _____

Local Health Department:: *Please mail a copy of this form along with the prescription(s) to the TB Program to initiate treatment and then mail it again upon completion or termination of treatment.*

Patient Name: _____
Address: _____ City: _____
DOB: _____ Sex: _____ Race: _____
Occupation: _____ Employer: _____
Attending Physician: _____ Phone: _____
Public Health Manager: _____

1. **Reason for TST/Mantoux**: ( ) Contact of known TB case; Name of case _____
   ( ) Foreign born; Country of origin _____
   ( ) Occupational _____
   ( ) Other _____

2. **TST Skin Test**: **1st Test**
   Date: _____
   Induration in mm: _____
   Person reading: _____

   2nd Test (if required)
   Date: _____
   Induration in mm: _____
   Person reading: _____

   Do patient records document this as a new infection (occurring within the past 2 years)? ___ Yes ___ No

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**: INH start date: _____ Prescribed length of therapy (months) _____
   If not on INH, list med: _____

When patient completes or otherwise ends treatment of LTBI fill out this section and mail the entire form to the TB Program at DPHHS

INH or other med LTBI therapy date completed: _____
INH or other med discontinued date: _____
If med discontinued, check reason:
___ Diagnosed with active TB
___ Moved, records referred to: _____
___ Medical Suspension due to adverse reaction
___ Noncompliant
___ Lost to follow up
___ Death

Submitted by: _____ Agency: _____ Today's Date: _____