CHECKLIST FOR LATENT TUBERCULOSIS INFECTION TREATMENT

Practitioner Name: **Patient Name:**

_____ _____

Please check the appropriate boxes.

☐ **1.** Has this patient had a positive skin test?

Date test measured: ____/____/_____

Result of test: (Please check one)

☐ ≥ 15 mm induration.

☐ ≥ 10 mm induration and the patient has some risk factors for TB. (e.g. recent arrival to U.S., resident or employee of congregate settings such as healthcare workers, child < 4 years)

☐ ≥ 5 mm induration and the patient is immunosuppressed, HIV-infected, a contact to an active case of TB, or shows radiographic evidence of previous TB infection.

Was the patient vaccinated with BCG in his/her country of origin?

☐ No ☐ Yes Date of vaccination: ____/____/_____

☐ **2.** The patient has **NO** signs or symptoms, and radiographic evidence of active TB.

Date of chest x-ray: ____/____/_____

☐ **3.** The patient is willing and able to complete a full course of therapy.

☐ **4.** The patient will be available for clinical monitoring during the full course of treatment.

☐ **5.** The patient has **NO** medical contraindications to treatment. (e.g. severe liver disease or drug sensitivity)

☐ **6.** The proper label will be attached to the medication.

☐ **7.** The patient has been counseled about drug interactions and side effects.

☐ 8. The practitioner will dispense the medication incident to practice.

_____ _____

Practitioner signature Date