

	Division of Community and Public Health	
	Section: Appendices	Revised May 2020
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ANNUAL STATEMENT FOR TUBERCULIN REACTORS

NAME: _____

DATE OF BIRTH: _____

SIGNS/SYMPTOMS SCREENING (Yes/No):

_____ Cough lasting longer than three (3) weeks

_____ Unexplained fever

_____ Night sweats

_____ Unexplained weight loss

_____ Coughing up blood

_____ Chest pain

IF NONE OF THESE SYMPTOMS ARE PRESENT, A CHEST X-RAY IS NOT NECESSARY.

Nurse/Physician

Date

[] I am tuberculin positive with negative CXR. I have had the recommended course of treatment for **Latent Tuberculosis Infection** (LTBI).

[] I am tuberculin positive. I have completed the recommended course of treatment for **Tuberculosis Disease**.

[] I am tuberculin positive and have not completed the recommended course of treatment.

If I develop any of the above symptoms, I agree to seek immediate medical attention.

Patient

Date

(Please Use LPHA letterhead)

OR

Insert LPHA Name

Address

City, State, Zip Code

Latent Tuberculosis Infection (LTBI) Treatment Completion

This letter is to certify that _____, ____/____/____
(Patient's Full Name) (Date of Birth)

has completed a recommended regimen for LTBI: _____ for
(Medication/Dosage/Frequency)

_____ months, from _____ to _____.
(# of) (Month/Year) (Month/Year)

It is recommended that you are evaluated annually by a medical provider for signs and symptoms of active TB disease. If you develop any of the following signs or symptoms of active TB disease, at any time, seek immediate medical attention, including a posterior/anterior chest x-ray. (Please wear a surgical mask to the emergency room, urgent care, or medical provider's office)

Signs and symptoms of active TB disease:

- ✓ Cough lasting longer than (3) weeks and/or coughing up blood
- ✓ Unexplained weight loss
- ✓ Night sweats
- ✓ Unexplained fever

(Signature of Medical Provider/Nurse)

(Date)