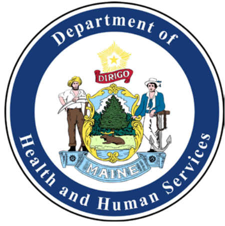

Maine CDC Tuberculosis Control Program: LTBI Treatment Referral

Phone: 207-287-8157 / Fax: 207-287-3727

Date of Referral:

DEMOGRAPHICS

Last Name: First Name: Date of Birth:

If patient <18 years, full name of parent/guardian:

Address: Sex: Male Female

City: State: Zip:

Phone:

Race (check all that apply):

- White
- Asian
- Black/African American
- Pacific Islander
- American Indian or Alaska Native

Ethnicity (check one):

- Non-Hispanic
- Hispanic

Patient's Health Insurance plan:

Patient does not have health insurance

Plan/Member number:

Patient's Language:

Patient's Country of Birth:

SCREENING INFORMATION

**Has clinician ruled out active TB disease (i.e., no TB-related symptoms or physical findings)? Yes

Patient weight: kg

Reason for Testing:

- Contact to Active TB Case
- Foreign Born
- Substance Abuse
- Immunocompromised
- Lives in Congregate Setting
- Diabetic
- High Risk Occupation
- Immigration Health Screening

Screening Test: Date:

TST mm of induration

QuantiFERON Pos Neg Indeterminate

T-Spot Pos Neg Indeterminate

Chest Imaging:

Chest Xray date:

- Normal
- Abnormal – not active TB
- Abnormal – consistent w/ active TB disease

Chest CT date:

- Normal
- Abnormal – not active TB
- Abnormal – consistent w/ active TB disease

Version: Aug 2023

Pt Last Name: Pt First Name: Date of Birth:

TREATMENT INFORMATION

Ordering Provider:

Provider Phone:

Provider Fax:

Pharmacy Name:

Pharmacy Phone:

Liver Function Tests:

Date collected:

ALT:

AST:

Treatment Regimen:

Medication	Dose	Route & Frequency	Date ordered
Isoniazid	mg		
Rifampin	mg		
Isoniazid + Rifapentine	mg		
Pyridoxine (Vit B6)	mg		
Other:	mg		

PERSON COMPLETING THE REFERRAL

Name: Phone number:

Organization/Practice:

NOTE: If you are requesting Public Health Nursing services, a Public Health Nursing (PHN) Service Request form must be submitted along with the LTBI Treatment Referral form.

Office Use Only:

Date received by TBC: Pharmacist Name:

Date faxed to PHN CREF: Sender: Patient ID#:

Pt Last Name: Pt First Name: Date of Birth:

PUBLIC HEALTH NURSING (PHN) SERVICE REQUEST

PHN services are available for patients needing clinical support to complete treatment and who meet specific criteria based on medical risk factors.

PHN services are being requested for one or more of the following criteria for referral:

Complicated latent tuberculosis infection (LTBI) defined as:

- ✓ a positive TB test (skin test or blood test) **and**
- ✓ chest Xray not consistent with active TB **and**
- ✓ at least one high risk factor for progression or treatment complexity:

Abnormal chest Xray consistent with old, healed TB

Immunosuppression: HIV infection, transplant recipient, treatment with TNF-alpha antagonist, steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

End-stage renal disease on hemodialysis

Children under 5 years of age (0-4 years old)

Contact to an active case or new TB test conversion to positive (previously documented negative test)

Intolerant of two or more LTBI regimens or underlying liver disease with abnormal LFTs

On medication-assisted treatment for substance use disorder

For other complications or categories not listed, please call Public Health Nursing central office at (1-888-644-1130) to discuss the referral. If approved, please indicate below the name of the person you spoke with and the date of the conversation.

Name of Public Health Nurse: Date of conversation:

Conversation summary:

Be sure to include this form with the LTBI Treatment Referral form.

Please note, PHN does not accept service requests for the following:

- General TB screening
- Employment or school TB screening
- Asymptomatic patients with prior history of completing LTBI treatment
- Asymptomatic patients with a normal chest x-ray, no special medical condition, and a positive TB skin test (TST) or TB interferon gamma release assay (IGRA, commercially available as QuantiFERON-TB Gold or T-SPOT.TB)