

# Forms:

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Alaska TB Program: Timeline for Case Management of Tuberculosis Treatment

Anchorage State Public Health Laboratory Request Form – Fillable form:

<http://dhss.alaska.gov/dph/Labs/Documents/publications/AncSupplyReq.pdf>

Consent for Release of Medical Information

Contact Investigation Form      ructio

Contact Investigation Form ( 0 pages)

DOT Calendar

DOT Direct Deposit

DOT Job Description (2 pages)

DOT Memorandum of Agreement

DOT Monthly Invoice for Payment

DOT Plan

DOT W9

End of Treatment Letter and Summary (2 pages)

Infectious Disease Report Form – Fillable form:

<http://dhss.alaska.gov/dph/Epi/Documents/pubs/conditions/frmInfect.pdf>

Interjurisdictional TB Notification – Fillable form:

[http://www.tbcontrollers.org/docs/resources/IJN\\_Form\\_May2015.pdf](http://www.tbcontrollers.org/docs/resources/IJN_Form_May2015.pdf)

Interjurisdictional TB Notification Follow-Up – Fillable form:

[http://www.tbcontrollers.org/docs/resources/IJN\\_FollowUpForm\\_November2014.pdf](http://www.tbcontrollers.org/docs/resources/IJN_FollowUpForm_November2014.pdf)

Liver Function Test Flowsheet

LTBI Treatment Completion Form and Instructions (2 pages)

PPD Order Form

Referral and Authorization for TB Screening and Follow-Up Services (2 pages)

Sputum Collection Guidelines

TB Case Management Form

TB Case Management Information Request

TB Discharge Planning Checklist

TB Medication Drug Count Worksheet

TB/LTBI Medication Request

TB/LTBI Medication Request - Guidelines (4 pages)

TB/LTBI Medication Return Form

Tuberculosis Screening Questionnaire/Chest X-ray Interpretation Request (2 pages)

Tuberculosis Screening Questionnaire Guidelines

Tuberculosis Treatment Contract (2 pages)

Activity	Weeks								Months					End of treatment evaluation	
	0	1	2	3	4	5	6	7	8	3	4	5	6		9 ⑤
	Initial Treatment Phase								Continuation Treatment Phase						
Clinical & lab evaluation History & Physical CBC, platelets, creatinine, AST, bilirubin, alk. phosph. Visual acuity, color vision HIV test	X														Not recommended
	X														
<b>Drugs</b>	Isoniazid (INH) _____ Rifampin (RIF) _____ Pyrazinamide (PZA) _____ Ethambutol (EMB) _____														
<b>Treatment options</b>	<b>All doses should be taken using directly observed therapy (DOT)</b> Regimens listed in order of effectiveness, with 1 being the MOST effective and preferred regimen														
1.) INH, RIF, PZA, EMB ④	Dose daily (7 days/wk) for 56 doses (8 wks) or 5 days/wk for 40 doses (8 wks). Preferred regimen for patients with newly diagnosed pulmonary TB.								7 days/wk for 126 doses (18 wks) 5 days/wk for 90 doses or twice wklly for 36 doses (18 wks)					⑤	
2.) INH, RIF, PZA, EMB ④	Dose daily (7 days/wk) for 56 doses (8 wks) or 5 days/wk for 40 doses (8 wks). Preferred regimen when more frequent DOT during continuation phase is difficult to achieve.								3 days/week for 54 doses (18 wks)					⑤	Count doses delivered by DOT to assure treatment completion ⑥
3.) INH RIF, PZA, EMB ④	Dose three times wklly for 24 doses (8 wks.); use regimen with caution in patients with HIV and/or cavitory disease. Missed doses can lead to treatment failure, relapse and acquired drug resistance.								Three times wklly for 54 doses (18 wks)					⑤	
4.) INH, RIF,PZA, EMB ④	7 days/wk for 14 doses then twice weekly for 12 doses. Do not use twice-weekly regimens in HIV-infected patients or patients with smear-positive and/or cavitory disease. If doses are missed, then therapy can be equivalent to once weekly, which is inferior.								Twice weekly for 36 doses (18 wks)						
<b>Sputum collection ⑦</b>	X				X				X	Collect sputa at least monthly until culture conversion occurs					
<b>Chest x-ray</b>	X									(X)	⑧				Optional
<b>Clinical assessment during treatment ⑨</b>	X				X				X	X	X	X	X	X	
<b>DOT &amp; compliance evaluation ⑩</b>	X				X				X	X	X	X	X	X	
<b>Contact investigation</b>	Screen priority contacts (TST/IGRA or SX & sputa)								Repeat TSTs/IGRA if initially negative					Confirm completion of contact investigation	

① Repeat liver enzyme tests if signs of drug toxicity appear during treatment. Perform monthly liver enzyme tests if high risk for hepatic toxicity (e.g. pre-existing liver disease or with abnormal liver function that does not require discontinuation).

② Discontinue pyrazinamide after 8 weeks

③ Discontinue ethambutol if *M. tuberculosis* is sensitive to all first line anti-tuberculosis agents.

④ Refer to OMTS/CDC/IDSA Treatment of Drug-Susceptible Tuberculosis 2016 Guidance which can be found at <http://cid.oxfordjournals.org/content/63/7/e147.full.pdf+html>

⑤ Patients with cavitation on initial CXR and (+) culture at completion of 2 months treatment should receive a 7-month continuation phase.

⑥ Consult the Alaska TB program to verify count of DOT doses and determine end of treatment date.

⑦ Collect 3 sputa monthly until all 3 are culture negative. Consider more frequent collection if clinically indicated. Repeat susceptibility testing if cultures positive after 3 mos of treatment.

⑧ If the patient is culture-negative, a repeat CXR is indicated during treatment to demonstrate improvement. A repeat CXR may also be useful if sputum specimens remains culture positive > 3 mo.

⑨ Perform monthly clinical assessments throughout treatment. Ask about nausea, vomiting, abdominal pain or swelling, jaundice, joint pain, vision changes, tingling extremities, or flu-like symptoms. When EMB is part of the regimen, test visual acuity and color vision.

⑩ Assess adherence to DOT & treatment plan. Use incentives & enablers. Report ≥ 2 missed DOT doses to the Alaska TB Program.



## Instructions for Completing the Tuberculosis Contact Investigation Form

The goals of a contact investigation are (1) rapid identification of individuals who are high and medium priority contacts to a known or suspected case of pulmonary, laryngeal or pleural TB; 2) timely initiation of appropriate treatment for those determined to be recently infected or exposed with a significant risk for progression to disease; and 3) identification and treatment of additional individuals found to have suspected TB disease in order to prevent further spread of disease.

This form is used by public health nurses (PHN) to guide and document the examination of contacts to active cases of pulmonary tuberculosis (TB) and the identification of the source of infection for cases of tuberculosis in children  $\leq 6$  yrs of age and tuberculin converters  $< 2$  years of age. Aggregate contact investigation data are also used by the Alaska TB Program for management and evaluation.

The **initial copy** of the form should be submitted to the Alaska TB Program as soon as the first round of TSTs or IGRA testing are completed. This should occur within **10 business days after the index case is reported to the PHN**. Some data fields may not be known until the final copy of the form is completed (e.g. last exposure date). Leave those fields blank on the initial copy and complete on the final copy. The **final copy** should be submitted when contact follow-up is complete, or approximately **8 – 10 weeks after the index case was initially reported** to the PHN.

### CASE

- **Demographics:** name, date of birth, race, gender at birth, phone number, address.
- **Infectious Period:** Review Table 1 to establish the infectious period. Additional epidemiologic or clinical factors may affect the infectious period and should be considered on a case-by-case basis.
- **Site of TB:** Indicate pulmonary or extra pulmonary.
- **Cavitary:** Select YES if the CXR interpretation indicated cavitary lesions.
- **Medication start date:** Enter the date that appropriate DOT drug therapy began (date first dose was administered via DOT).
- **Lab results:** AFB smear, PCR and sputum mycobacterial culture results. Enter the collection date of the initial positive specimen. Sensitivities to isoniazid, rifampin, ethambutol, pyrazinamide and streptomycin and start date of TB medications.

**Table 1. Establishing an Infectious Period (IP)**

<b>Patients with sputum smear positive for AFB OR cavitary chest x-ray OR with TB symptoms (e.g. cough, hoarseness)</b>	<b>Patients with sputum smear negative for AFB, AND non-cavitary chest x-ray AND NO TB symptoms</b>
<p>Date of Symptom onset: _____ or</p> <p>Date of first positive finding: _____</p> <p><b>IP Start Date: 3 months</b> prior to symptom onset or 1<sup>st</sup> positive finding consistent with TB disease (whichever is longer): _____</p>	<p>Date treatment started: _____</p> <p><b>IP Start Date: 4 weeks</b> prior to date of diagnosis (date treatment started): _____</p>
<p>1) Date 14<sup>th</sup> dose of DOT TB administered: _____</p> <p>2) Date 3rd consecutive AFB-negative smear sputa specimen was collected: _____</p> <p>3) Date clinical improvement noted: _____</p> <p><b>IP End Date:</b> All three of the above criteria need to be met: completion and tolerance of 2 weeks of appropriate TB treatment (via DOT), 3 consecutive negative sputum AFB smears, and clinical improvement. <b>The IP end date is the latest date out of the 3 criteria:</b> _____</p>	<p>Date the 7<sup>th</sup> dose of DOT TB treatment administered: _____</p> <p><b>IP End Date:</b> After 7 days of appropriate DOT, TB treatment, is taken and tolerated and no risk for drug resistance (Same date as recorded above): _____</p>

*NOTE: For MDR cases regardless of sputum AFB smear status, cavitation on chest x-ray or TB symptoms, the closure of the infectious period will differ. MDR cases will require additional criteria of at least 3 consecutive negative sputum cultures without a subsequent positive culture and 14 days of TB treatment*

**Estimated Infectious Period:** \_\_\_\_\_ **to** \_\_\_\_\_  
**Start** **End**

Tool adapted from LA County Toolkit <http://publichealth.lacounty.gov/tb/docs/CIToolkit2013.pdf>

## **CONTACTS**

- **Demographics:** name, date of birth, race, gender at birth, phone number, address and relationship to case, e.g., share same house-hold, co-worker, daughter, spouse, friend.
- **Contact Priority:** Any contacts who are not classified as high or medium priority are assigned a low priority. Review Table 2 to determine contact priorities.

**Table 2. Contact Priorities**

Contact Priority	
High	Includes contacts who meet the following criteria: household, ages <5 years, HIV or other medical risk, contact during bronchoscopy, sputum induction, etc., contact in congregate setting, or exceeds environmental limits
Medium	Includes contacts ages 5–15 years or who exceed environmental limits
Low	Includes all others
Consider window period prophylaxis for children < 5 years of age and immunocompromised persons.	

- **Dates exposed to infectious case:** Document the date the contact was first exposed to the index case WHILE the index case was considered infectious. Document the last day the contact was exposed to the index case WHILE the index case was considered infectious. Use the index case’s calculated infectious period to determine contact exposure dates. If contact is ongoing AND case is infectious, leave end date blank until final evaluation.
- **Historical Information, if available:**
  - Past TST or Past IGRA: Document screening results/date
  - Treatment History: Document prior LTBI or Active TB treatment/dates of treatment
- **Initial evaluation:**
  - Initial TST or IGRA: Document screening results/date
  - Symptom Screening: Select Yes if the contact has symptoms of tuberculosis such as cough, weight loss, fever, night sweats, fatigue, and/or hemoptysis. Document the date the symptom screening was done.
  - Sputa: If sputa were collected, document collection dates /results.
  - Chest X-ray: Document whether the CXR results were read as normal or abnormal. Provide brief details on abnormalities as noted by radiologist.
- **Final Evaluation:**
  - Follow-up TST or IGRA should be done 8 weeks after the last exposure to the index case while the index case was considered infectious. Document screening results/date
- **Contact’s Evaluation Summary:**
  - Evaluation complete: Select Yes or No, and the date and name of the PHN who completed the contact investigation.
  - Conclusion: Document the final status of the contact investigation.
  - Comments: Document any relevant details not captured in the form.

INDEX CASE Name:

DOB:

Infectious Period Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**INDEX CASE INFORMATION**

Race:		Gender at Birth:		Phone Number:	
Address:			City:		Zip code:
Site of TB: <input type="checkbox"/> Pulmonary <input type="checkbox"/> Extrapulmonary			Cavitary: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Medication Start Date:
Lab Results	Smear: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		Date of Sputa Collection:		
	Culture: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		Sensitive to (select all that apply): <input type="checkbox"/> INH <input type="checkbox"/> RIF <input type="checkbox"/> EMB <input type="checkbox"/> PZA <input type="checkbox"/> STR		
	PCR: <input type="checkbox"/> Positive <input type="checkbox"/> Negative				

Contact Name:		Date of Birth:		Relationship to case:	
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low		Dates exposed to infectious case: Start Date		End Date	
Race:		Gender at Birth:		Phone Number:	
Address:			City:		Zip code:
<b>Historical Information</b>					
Past TST	Date:	Result:	mm	Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown	
Past IGRA	Date:	Result:		Start Date:	End Date:
<b>Initial Evaluation</b>					
Initial TST	Date:	Result:	mm	Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Initial IGRA	Date:	Result:		Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic	
Sputa	Date:	Smear:	Culture:	PCR:	Chest Xray: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):
	Date:	Smear:	Culture:	PCR:	
	Date:	Smear:	Culture:	PCR:	
<b>Final Evaluation:</b>					
Follow Up TST/IGRA 'F w g' F c v g' *: 'y g g m' c h m g t' g z r q u w g' r g t k q f ' g p f ' f c v g <					
Follow-up TST	Date:	Result:	mm	Follow-up IGRA	Date: Result:
<b>Contact's Evaluation Summary:</b>					
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:			Comments:		
Completed by:					
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow-Up					

**CLEAR FORM**

INDEX CASE Name:

DOB:

Infectious Period Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Contact Name:		Date of Birth:			Relationship to case:	
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low		Dates exposed to infectious case:		Start Date	End Date	
Race:		Gender at Birth:			Phone Number:	
Address:		City:			Zip code:	
<b>Historical Information</b>						
Past TST	Date:	Result:	mm	Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown		
Past IGRA	Date:	Result:		Start Date:	End Date:	
<b>Initial Evaluation</b>						
Initial TST	Date:	Result:	mm	Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:		
Initial IGRA	Date:	Result:		Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic		
Sputa	Date:	Smear:	Culture:	PCR:	Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
	Date:	Smear:	Culture:	PCR:	Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):	
	Date:	Smear:	Culture:	PCR:		
<b>Final Evaluation:</b>						
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):						
Follow-up TST	Date:	Result:	mm	Follow-up IGRA	Date:	Result:
<b>Contact's Evaluation Summary:</b>						
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:			Comments:			
Completed by:						
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow-Up						

Contact Name:		Date of Birth:			Relationship to case:	
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low		Dates exposed to infectious case:		Start Date	End Date	
Race:		Gender at Birth:			Phone Number:	
Address:		City:			Zip code:	
<b>Historical Information</b>						
Past TST	Date:	Result:	mm	Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown		
Past IGRA	Date:	Result:		Start Date:	End Date:	
<b>Initial Evaluation</b>						
Initial TST	Date:	Result:	mm	Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:		
Initial IGRA	Date:	Result:		Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic		
Sputa Collected	Date:	Smear:	Culture:	PCR:	Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
	Date:	Smear:	Culture:	PCR:	Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):	
	Date:	Smear:	Culture:	PCR:		
<b>Final Evaluation:</b>						
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):						
Follow-up TST	Date:	Result:	mm	Follow-up IGRA	Date:	Result:
<b>Contact's Evaluation Summary:</b>						
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:			Comments:			
Completed by:						
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow-Up						

INDEX CASE Name:

DOB:

Infectious Period Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Contact Name:	Date of Birth:	Relationship to case:
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Dates exposed to infectious case: Start Date	End Date
Race:	Gender at Birth:	Phone Number:
Address:	City:	Zip code:
<b>Historical Information</b>		
Past TST Date: Result: mm	Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown	
Past IGRA Date: Result:	Start Date: End Date:	
<b>Initial Evaluation</b>		
Initial TST Date: Result: mm	Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Initial IGRA Date: Result:	Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic	
Sputa Collected Date: Smear: Culture: PCR:	Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Date: Smear: Culture: PCR:	Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):	
Date: Smear: Culture: PCR:		
<b>Final Evaluation:</b>		
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):		
Follow-up TST Date: Result: mm	Follow-up IGRA Date:	Result:
<b>Contact's Evaluation Summary:</b>		
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	Comments:	
Completed by:		
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up		

Contact Name:	Date of Birth:	Relationship to case:
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Dates exposed to infectious case: Start Date	End Date
Race:	Gender at Birth:	Phone Number:
Address:	City:	Zip code:
<b>Historical Information</b>		
Past TST Date: Result: mm	Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown	
Past IGRA Date: Result:	Start Date: End Date:	
<b>Initial Evaluation</b>		
Initial TST Date: Result: mm	Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Initial IGRA Date: Result:	Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic	
Sputa Collected Date: Smear: Culture: PCR:	Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Date: Smear: Culture: PCR:	Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):	
Date: Smear: Culture: PCR:		
<b>Final Evaluation:</b>		
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):		
Follow-up TST Date: Result: mm	Follow-up IGRA Date:	Result:
<b>Contact's Evaluation Summary:</b>		
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	Comments:	
Completed by:		
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up		

INDEX CASE Name:

DOB:

Infectious Period Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Contact Name:	Date of Birth:	Relationship to case:		
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Dates exposed to infectious case:		Start Date	End Date
Race:	Gender at Birth:	Phone Number:		
Address:	City:	Zip code:		
<b>Historical Information</b>				
Past TST	Date:	Result:	mm	Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown Start Date: _____ End Date: _____
Past IGRA	Date:	Result:		
<b>Initial Evaluation</b>				
Initial TST	Date:	Result:	mm	Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic
Initial IGRA	Date:	Result:		
Sputa Collected	Date:	Smear:	Culture:	PCR:
	Date:	Smear:	Culture:	PCR:
	Date:	Smear:	Culture:	PCR:
Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify): _____				
<b>Final Evaluation:</b>				
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date): _____				
Follow-up TST	Date:	Result:	mm	Follow-up IGRA Date: _____ Result: _____
<b>Contact's Evaluation Summary:</b>				
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____			Comments:	
Completed by: _____				
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up				

Contact Name:	Date of Birth:	Relationship to case:		
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Dates exposed to infectious case:		Start Date	End Date
Race:	Gender at Birth:	Phone Number:		
Address:	City:	Zip code:		
<b>Historical Information</b>				
Past TST	Date:	Result:	mm	Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown Start Date: _____ End Date: _____
Past IGRA	Date:	Result:		
<b>Initial Evaluation</b>				
Initial TST	Date:	Result:	mm	Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic
Initial IGRA	Date:	Result:		
Sputa Collected	Date:	Smear:	Culture:	PCR:
	Date:	Smear:	Culture:	PCR:
	Date:	Smear:	Culture:	PCR:
Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify): _____				
<b>Final Evaluation:</b>				
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date): _____				
Follow-up TST	Date:	Result:	mm	Follow-up IGRA Date: _____ Result: _____
<b>Contact's Evaluation Summary:</b>				
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____			Comments:	
Completed by: _____				
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up				

INDEX CASE Name:

DOB:

Infectious Period Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Contact Name:				Date of Birth:				Relationship to case:			
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low				Dates exposed to infectious case: Start Date				End Date			
Race:				Gender at Birth:				Phone Number:			
Address:				City:				Zip code:			
<b>Historical Information</b>											
Past TST Date: Result: mm				Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown							
Past IGRA Date: Result:				Start Date:				End Date:			
<b>Initial Evaluation</b>											
Initial TST Date: Result: mm				Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:							
Initial IGRA Date: Result:				Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic							
Sputa Collected Date: Smear: Culture: PCR:				Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:							
Date: Smear: Culture: PCR:				Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):							
Date: Smear: Culture: PCR:											
<b>Final Evaluation:</b>											
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):											
Follow-up TST Date: Result: mm				Follow-up IGRA Date:				Result:			
<b>Contact's Evaluation Summary:</b>											
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:						Comments:					
Completed by:											
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up											

Contact Name:				Date of Birth:				Relationship to case:			
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low				Dates exposed to infectious case: Start Date				End Date			
Race:				Gender at Birth:				Phone Number:			
Address:				City:				Zip code:			
<b>Historical Information</b>											
Past TST Date: Result: mm				Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown							
Past IGRA Date: Result:				Start Date:				End Date:			
<b>Initial Evaluation</b>											
Initial TST Date: Result: mm				Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:							
Initial IGRA Date: Result:				Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic							
Sputa Collected Date: Smear: Culture: PCR:				Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:							
Date: Smear: Culture: PCR:				Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):							
Date: Smear: Culture: PCR:											
<b>Final Evaluation:</b>											
Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):											
Follow-up TST Date: Result: mm				Follow-up IGRA Date:				Result:			
<b>Contact's Evaluation Summary:</b>											
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:						Comments:					
Completed by:											
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up											

INDEX CASE Name:

DOB:

Infectious Period Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Contact Name:	Date of Birth:	Relationship to case:
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Dates exposed to infectious case: Start Date	End Date
Race:	Gender at Birth:	Phone Number:
Address:	City:	Zip code:
<b>Historical Information</b>		
Past TST Date: Result: mm	Treatment history: <input type="checkbox"/> LTBI <input type="checkbox"/> Active TB <input type="checkbox"/> None <input type="checkbox"/> Unknown	
Past IGRA Date: Result:	Start Date: End Date:	
<b>Initial Evaluation</b>		
Initial TST Date: Result: mm	Symptom Screening <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Initial IGRA Date: Result:	Result: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic	
Sputa Collected Date: Smear: Culture: PCR:	Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Date: Smear: Culture: PCR:	Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify):	
Date: Smear: Culture: PCR:		
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Follow Up TST/IGRA Due Date (8 weeks after exposure period end date):		
Follow-up TST Date: Result: mm	Follow-up IGRA Date:	Result:
<b>Contact's Evaluation Summary:</b>		
Evaluation complete? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	Comments:	
Completed by:		
Conclusion: <input type="checkbox"/> Cleared <input type="checkbox"/> Active TB <input type="checkbox"/> LTBI <input type="checkbox"/> Lost to Follow- Up		

Contact Name:	Date of Birth:	Relationship to case:
Contact Priority: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Dates exposed to infectious case: Start Date	End Date
Race:	Gender at Birth:	Phone Number:
Address:	City:	Zip code:
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# Directly Observed Therapy (DOT) Calendar

**STOP TB DRUGS and contact your local CHAP or PHN if your client has any of the problems listed below:**

<input type="checkbox"/> Decrease in appetite	<input type="checkbox"/> Dark Urine
<input type="checkbox"/> Jaundice (yellow skin or eyes)	<input type="checkbox"/> Rash or Itching
<input type="checkbox"/> Nausea or upset stomach	<input type="checkbox"/> Fatigue (very tired)
<input type="checkbox"/> Stomach Pain	<input type="checkbox"/> Tingling or burning in hands or feet
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Visual changes
<input type="checkbox"/> Fever	

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Meds Given <input type="checkbox"/>						
Initial _____						
Meds Given <input type="checkbox"/>						
Initial _____						
Meds Given <input type="checkbox"/>						
Initial _____						
Meds Given <input type="checkbox"/>						
Initial _____						
Meds Given <input type="checkbox"/>						
Initial _____						

Medications, Dosage & Schedule \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient Name \_\_\_\_\_

HR # \_\_\_\_\_

Village \_\_\_\_\_

DOT Aide \_\_\_\_\_

Month \_\_\_\_\_

**Note: The AK TB Program will only reimburse DOT aides for up to 5 doses per week unless pre-approved.**

# STATE OF ALASKA

## ELECTRONIC PAYMENT AGREEMENT

**Fax completed form to:**  
 Dept of Public Health/ Epidemiology  
 FAX: (907) 563-7868  
 Questions? Call (907) 269-8000 or (907) 465-5622

\* Indicates required field.

### FOR VENDORS DOING BUSINESS WITH THE STATE OF ALASKA

#### PAYEE INFORMATION

STATE OF ALASKA VENDOR NUMBER		TAXPAYER ID - SSN / EIN *		<i>ID number assigned to the legal name below and used for tax reporting</i>	
LEGAL NAME * <i>(Name that Tax ID above is assigned to and is used for tax reporting)</i>					
BUSINESS NAME <i>(DBA - Doing Business As Name. If different from legal name shown above)</i>					
IS MAILING ADDRESS NEW? * YES / NO	MAILING ADDRESS *	CITY	STATE	ZIP CODE + 4	
CONTACT NAME	DAYTIME PHONE *	CONTACT EMAIL ADDRESS	EMAIL ADDRESS <i>for copies of remit advice</i>		

#### BANKING INFORMATION

The State of Alaska sends a pre-note zero dollar test transaction to verify the accuracy of the banking information below. Payments will not be sent electronically until the pre-note process is complete, generally five business days. The State of Alaska will contact you if the pre-note fails.

**ARE YOU ADDING, CHANGING (must provide PRIOR acct info) OR CANCELLING THIS AGREEMENT? \***

*Please attach a voided check or other bank verification of account number as applicable*

<b>CURRENT ACCOUNT INFORMATION *</b>		<b>PRIOR ACCOUNT INFORMATION (for Changes only)</b>	
FINANCIAL INSTITUTION NAME	ACCOUNT TYPE	<i>For verification purposes you must provide your prior account information if you are requesting a change.</i>	
ACCOUNT NAME (Business / Legal Name on Account)	Checking Savings	ABA/ROUTING TRANSIT NUM	FULL ACCOUNT NUMBER
ABA/ROUTING TRANSIT NUMBER	FULL ACCOUNT NUMBER		

**IS THIS ACCOUNT PRIMARILY A PERSONAL OR BUSINESS ACCOUNT? \* PERSONAL - OR - BUSINESS**

**FOR BUSINESS ACCOUNTS.** Choose ONE of the business account addenda information format options below.

Payments deposited separately with one addendum (remittance) record for each payment.      Payments combined into one deposit with multiple addenda (remittance) records for each payment in the deposit.

NACHA Operating Rules requires your banking institution to provide you with addenda (remittance) information that the State includes on each payment. Any banking charge to receive this information is the responsibility of the account holder.

#### AGREEMENT AND AUTHORIZATION

I hereby authorize the State of Alaska to satisfy payment obligations due me by making deposits to the account indicated above. I understand that receipt of the electronic fund transfer(s) will fulfill the State's payment obligation and the State will be credited for the full amount on the date the fund transfer is completed. I understand the State will make a reasonable effort to notify me within 24 hours if a reversing entry is made against this account. This authority is to remain in full force through the duration of this agreement. I understand that thirty (30) days written notice is required if I change financial institutions, account numbers or type of account.

In addition, as required by the Federal Office of Foreign Asset Control in support of U.S.C. Title 50, War and National Defense, I attest that the full amount of my direct deposit is not being forwarded to a bank in another country and that if at any point I establish a standing order with my receiving bank to forward the full direct deposit to a bank in another country, I will inform the State of Alaska immediately.

I certify all information regarding this authorization is true and correct. Any intent to falsify information is punishable under AS 11.56.210 as a class A misdemeanor.

If the State discovers that the full amount of a direct deposit has been forwarded to another country or if information on the form has been falsified, this agreement shall be terminated. All correspondence with the State concerning this agreement or any changes to account information should be sent to the address at the top of this form. All terms remain in effect until this agreement is terminated by either party.

PRINTED NAME *	TITLE
SIGNATURE *	DATE *



## Directly Observed Therapy (DOT) Aide Job Description

### I. Overview:

Under the direct supervision of the local Public Health Nurse (PHN), acts a representative of the Alaska TB Program in the community to provide directly observed therapy (DOT) for patients with tuberculosis or latent tuberculosis infection (LTBI). The DOT Aide reinforces the importance of following medical advice, taking TB medications according to the prescribed schedule and regimen, and completing treatment to the patient. DOT Aides also monitor patient treatment and adverse reactions and report regularly to the local Public Health Nurse.

### II. Duties and Responsibilities:

#### A. Helps provide patient care.

1. Obtains TB medications from the PHN and ensures that they are stored safely and out of the reach of children at all times. Dose packs are NOT child proof and must be stored securely. PHNs can assist with safe storage options as needed.
2. Delivers directly observed therapy (DOT) following medical and nursing direction to ensure that the patient takes their TB medications according to the prescribed schedule. **DOT means that the Aide watches while the TB patient swallows their medication. Doses that are NOT observed are not counted.**
3. Reviews possible medication side effects with patient and family.
4. Asks about and observes patient for signs/symptoms of medication side effects **before** each DOT dose.
5. **STOPS TB drugs and reports any signs/symptoms of TB medication side effects as soon as possible to the PHN. These include: nausea; vomiting; stomach pain; decreased appetite; jaundice (yellow eyes or skin); fever; dark urine; rash or itching; fatigue; tingling or burning in hands or feet; or visual changes.**
6. Locates patient when patient misses appointment with the DOT Aide. Encourages patient cooperation with therapy.
7. Reports 2 or more missed DOT doses to the PHN Case Manager.
8. Keeps PHN informed of patient's progress, whereabouts, and any patient travel plans.

**B. Documents patient care activities and fills out required forms.**

1. Documents all medications and dosages given on the DOT Calendar.
2. Records each dose on the DOT Calendar on the day it is provided to the patient. **The Alaska TB program will only reimburse DOT Aides for up to 5 doses per patient per week unless approved by the Program before the doses are given.**
3. Submits completed DOT Calendar and Monthly Invoice for Payment to the PHN Case Manager at the end of each month.

**C. Organizes workload.**

1. Provides TB medications according to the plan agreed upon by the DOT Aide, PHN Case Manager, and the patient.
2. Makes a plan with the PHN Case Manager, in case DOT Aide needs time off.

**III. Supervision Received:**

The DOT Aide will be recruited, trained, and supervised by the local or itinerant PHN.

**IV. Qualifications and Requirements:**

- A. Must read and review the Alaska DOT Manual and clarify any questions or concerns with the PHN Case Manager before giving the patient DOT. The DOT Aide must sign the *Memorandum of Agreement* and send to the PHN. The Alaska DOT Manual should be used as a guide to best practices for DOT Aides.
- B. Must be able to deal tactfully and communicate effectively with patient(s). Must feel comfortable meeting patient(s) in unconventional settings such as work sites, homes, schools, and other places.
- C. Will be expected to maintain regular contact with the PHN Case Manager either in person or by phone to report on the patient's status and DOT regimen.
- D. Prior training in health care, health education, social work, or public health is desirable, but not required. Must be mature and dependable and have the ability to complete written forms.
- E. It is very important for DOT Aides to maintain the privacy of patients and their families. The patient's diagnosis, treatment, and related issues are confidential and should only be discussed with the PHN Case Manager and the patient's health care provider.



MEMORANDUM OF AGREEMENT between the Directly Observed Therapy (DOT) Aide and the Alaska TB Program

- 1. The DOT Aide will read the Alaska DOT Manual and acknowledge review of these training materials before administering DOT medications to patients. Each new DOT Aide will receive a one-time payment of \$25 for completing the training. If a DOT Aide is providing DOT to multiple patients, only one payment of \$25 is allowed per DOT Aide.
2. The DOT Aide will perform all duties and responsibilities outlined in the DOT Aide Job Description. This includes: ensuring safe and child proof storage of all medications; asking about side effects and stopping medications as instructed; notifying the PHN Case Manager if the patient does experience side effects or misses doses; watching the patient swallow each dose of medications; maintaining the patient's confidentiality; recording all doses on the Monthly DOT Calendar daily; and maintaining regular contact with the PHN Case Manager.
3. The DOT Aide will complete and mail or FAX a Monthly Invoice for Payment and a Monthly DOT Calendar to the PHN Case Manager after the last day of each month in which the Aide provides the patient with DOT services.
4. The DOT Aide will receive payment for their services once per month from the Alaska TB Program. This process takes up to 4 weeks from the time that the PHN sends the DOT Aide's approved Monthly Invoice for Payment and Monthly DOT Calendar to the Alaska TB Program.
5. Direct Deposit of funds into the DOT Aide's bank account is an option that makes payment faster. To request this, DOT Aides will need to complete and submit the Electronic Payment Agreement with the first invoice and calendar. Electronic payment requests take at least 1 billing cycle for processing.
6. The Alaska TB Program cannot guarantee the amount of work involved for each patient's care. The amount of work will vary depending on the patient's needs.
7. Job duties and responsibilities are described in the DOT Aide Job Description (see attached).

AGREEMENT

I, \_\_\_\_\_, \_\_\_\_\_, agree to provide tuberculosis medicines to
Name of DOT Aide Social Security #

\_\_\_\_\_, \_\_\_\_\_, of \_\_\_\_\_,
Name of Patient HR # Name of Village

Alaska for a period of time and according to directions specified by the patient's health care provider and the PHN Case Manager.

I understand I will be paid \$10.00 for each day I observe administration of TB medicines.

Signature of DOT Aide: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of PHN Case Manager: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Alaska TB Program: \_\_\_\_\_ Date: \_\_\_\_\_



**Alaska TB Program  
Section of Epidemiology  
3601 C Street, Suite 540  
Anchorage, AK 99503  
(907) 269-8000  
(907) 563-7868 (fax)**

**DOT AIDE MONTHLY INVOICE FOR PAYMENT**

Today's date: \_\_\_\_\_

Invoice for the month of: \_\_\_\_\_

Patient  
HR# \_\_\_\_\_

Completed review of AK DOT Aide  
Manual/training: \_\_\_/\_\_\_/\_\_\_

Number of daily DOT doses provided:  x \$10.00

\$25.00 (**one-time payment only**)

**Total payment requested: \$** \_\_\_\_\_

**Send payment to:**

Name: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PVN: \_\_\_\_\_

Signed: \_\_\_\_\_  
DOT Aide

Signed: \_\_\_\_\_  
PHN Case Manager

***Please fax this form and monthly calendar to:***

\_\_\_\_\_, PHN at 907-\_\_\_\_\_-\_\_\_\_\_

**DOT Plan for:**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Birthdate

DOT Aide: \_\_\_\_\_

\_\_\_\_\_  
Village

DOT Location: \_\_\_\_\_

Drug Storage Site: \_\_\_\_\_

- Consider patient infectious until \_\_\_\_\_. Make sure patient is masked during visit except to swallow pills. Do DOT outside if possible.
- Ask about side effects BEFORE medicines are taken. If patient reports side effects, such as stomach pain, vomiting, dark urine, etc., DO NOT GIVE MEDS and call PHN at \_\_\_\_\_.
- Patient will be taking these pills all at once at the same time from unit dose packages.

Drug	Dose	How Often	Comments
<input type="checkbox"/> Isoniazid (INH)	_____	_____	_____
<input type="checkbox"/> Rifampin (RIF)	_____	_____	_____
<input type="checkbox"/> Ethambutol (EMB)	_____	_____	_____
<input type="checkbox"/> Pyrazinamide (PZA)	_____	_____	_____
<input type="checkbox"/> Rifapentine (RPT)	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____

DO NOT GIVE ANY OTHER TB MEDICINES that patient or the clinic may have!

- PHN can provide juice, applesauce, or pudding for crushed pills if necessary.
- Watch to make sure that patient swallows all pills.
- Record all medicines, doses, dates, and your initials on the DOT Calendar.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

DOT Plan start date: \_\_\_\_\_

DOT Plan end date: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
PHN Case Manager

\_\_\_\_\_  
Date

\_\_\_\_\_  
DOT Aide



State of Alaska  
 Department of Administration  
**Substitute Form W-9**

Questions? Email [DOA.DOF.Vendor.HelpDesk@alaska.gov](mailto:DOA.DOF.Vendor.HelpDesk@alaska.gov)

Fax completed form to:

Dept of Public Health/ Epidemiology  
 FAX: (907) 563-7868  
 Questions? Call (907) 269-8000 or  
 (907) 465-5622

**DO NOT send to IRS**

**Taxpayer Identification Number (TIN) Verification**

The Internal Revenue Service requires the State of Alaska to issue 1099 forms when payments to individuals, partnerships or limited liability companies for rents, services, prizes, and awards meet or exceed \$600.00 for the year. An IRS Form 1099 is not required when payments are specifically for merchandise or made to some types of corporations.

*Print or Type*

Please see attachment or reverse for complete instructions

<b>Legal Name</b> (as shown on your income tax return)	<b>State of Alaska Vendor Number</b> (if known)
<b>Business Name</b> , if different from above (use if doing business as (DBA) or enter business name of Sole Proprietorship)	<b>Entity Designation</b> (check only one type)  Individual / Sole Proprietor Partnership General Corporation Medical Corporation Legal Corporation Limited Liability Company – Individual Limited Liability Company – Partnership Limited Liability Company – Corporation Government Entity Estate / Trust Organization Exempt from Tax - Nonprofit (under Section 501 (a)(b)(c)(d))
<b>Primary Address</b> (for 1099 form) PO Box or Number and Street, City, State, Zip + 4	
<b>Remit Address</b> (where payment should be mailed, if different from Primary Address) PO Box or Number and Street, City, State, Zip + 4	
	<b>Exemption</b> (See Instructions)  Exempt payee code (if any) Exemption from FATCA Reporting Code (if any)

**Taxpayer Identification Number (TIN) Provide Only One** (If sole proprietorship provide EIN, if applicable)

<b>Social Security Number (SSN)</b>	<b>Employer Identification Number (EIN)</b>
-------------------------------------	---

<b>If Change of Ownership or Entity Designation</b>	<b>Date of Change:</b>
<b>Previous Owner / Business Name</b>	<b>Previous Taxpayer Identification Number (TIN)</b>

**Certification**

*The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.*

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number, **AND**
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, **AND**
3. I am a U.S. person (including a U.S. resident alien), **AND**
4. The FATCA code(s) entered on this form (if any) indicating I am exempt from FATCA reporting is correct.

<b>Printed Name</b>	<b>Printed Title</b>	<b>Telephone Number</b>
<b>Signature</b>	<b>Date</b>	<b>Email Address</b>

# Instructions for Completing Taxpayer Identification Number (TIN) Verification (Substitute W-9) -- Page 1

## Legal Name

As registered with the Internal Revenue Service (IRS)

- Individuals: Enter First Name MI Last Name
- Sole Proprietorships: Enter First Name MI Last Name
- LLC Single Owner: Enter owner's First Name MI Last Name
- All Others: Enter Legal Name of Business

## Business Name

- Individuals: Leave blank
- Sole Proprietorships: Enter Business Name
- LLC Single Owner: Enter LLC Business Name
- All Others: Complete only if doing business as a DBA

## Primary Address

Address where 1099 tax form should be mailed.

## Remit Address

Address where payment should be mailed. Complete only if different from primary address.

## State of Alaska Vendor Number

Your vendor number is an eight character alphanumeric code assigned to your company in the State of Alaska's accounting system. You may contact us at the email address listed on the form if you do not know your vendor number.

## Entity Designation

Check *ONE* box which describes the type of business entity.

## Taxpayer Identification Number

**LIST ONLY ONE:** Social Security Number OR Employer Identification Number. **See "What Name and Number to Give the Requester" at right.**

If you do not have a TIN, apply for one immediately. Individuals use federal form SS-05 which can be obtained from the Social Security Administration. Businesses and all other entities use federal form SS-04 which can be obtained from the Internal Revenue Service.

## Change of Ownership or Entity Designation

This information is requested to allow taxable income to be reported correctly for both the new and old entities.

## Certification

You must cross out item 2 if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN.

## Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to furnish your correct TIN to persons who must file information

returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, or contributions you made to an IRA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not furnish a TIN to a payer. Certain penalties may also apply.

### What Name and Number to Give the Requester

<b>For this type of account:</b>	<b>Give name and SSN of:</b>
Individual	The individual
Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup>
Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
The usual revocable savings trust (grantor is also trustee)	The grantor-trustee <sup>1</sup>
So-called trust account that is not a legal or valid trust under state law	The actual owner <sup>1</sup>
Sole proprietorship or Single-Owner LLC	The owner <sup>1</sup>
<b>For this type of account:</b>	<b>Give name and EIN of:</b>
Sole Proprietorship or Single-Owner LLC	The owner <sup>3</sup>
A valid trust, estate, or pension trust	Legal entity <sup>4</sup>
Corporation or LLC electing corporate status on Form 8832	The corporation
Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
Partnership or multi-member LLC	The partnership
A broker or registered nominee	The broker or nominee
Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district or prison) that receives agricultural program payments	The public entity

<sup>1</sup> List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> **You must show your individual name**, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

<sup>4</sup> List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

**Note:** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

# Instructions for Completing Taxpayer Identification Number (TIN) Verification (Substitute W-9) -- Page 2

## Exemptions

If you are exempt from backup withholding and/or Foreign Account Tax Compliance Act (FATCA) reporting, enter in the Exemptions box any code(s) that may apply to you. See **Exempt payee code** and **Exemption from FATCA reporting code** below.

### Exempt payee code

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.

**Note.** If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following codes identify payees that are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)
2. The United States or any of its agencies or instrumentalities
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities
5. A corporation
6. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States
7. A futures commission merchant registered with the Commodity Futures Trading Commission
8. A real estate investment trust
9. An entity registered at all times during the tax year under the Investment Company Act of 1940
10. A common trust fund operated by a bank under section 584(a)
11. A financial institution
12. A middleman known in the investment community as a nominee or custodian
13. A trust exempt from tax under section 664 or described in section 4947

### Exemption from FATCA reporting code

The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements.

- A. An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)
- B. The United States or any of its agencies or instrumentalities
- C. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities
- D. A corporation the stock of which is regularly traded on one or more established securities markets, as described in Reg. section 1.1472-1(c)(1)(i)
- E. A corporation that is a member of the same expanded affiliated group as a corporation described in Reg. section 1.1472-1(c)(1)(i)
- F. A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state
- G. A real estate investment trust
- H. A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940
- I. A common trust fund as defined in section 584(a)
- J. A bank as defined in section 581
- K. A broker
- L. A trust exempt from tax under section 664 or described in section 4947(a)(1)
- M. A tax exempt trust under a section 403(b) plan or section 457(g) plan



**Alaska TB Program  
Section of Epidemiology  
3601 C Street, Suite 540  
Anchorage, AK 99503  
(907) 269-8000  
(907) 563-7868 (fax)**

Date:

Name

Address

Dear

Congratulations on completing your treatment for active Tuberculosis (TB). A summary of your TB treatment is attached. Please save this letter in your personal health record as proof of your TB treatment completion.

You need to remember the following about your TB status:

- Your TB skin test will always be positive. Do not take any more TB skin tests in the future.
- If you need TB clearance for employment or school, ask for a TB symptom questionnaire, which asks questions about your current health status.
- You may have your health care provider or a local public health nurse give you a TB symptom questionnaire should you need one.
- There is a small risk that you might develop TB again. See your health care provider to make sure you do not have active TB if you develop any of these symptoms:
  - Cough that will not go away
  - Fever
  - Weight loss
  - Night sweats

•  
If you have any questions about this letter, please call your local public health nurse at \_\_\_\_\_.

Sincerely,

\_\_\_\_\_ PHN, \_\_\_\_\_ Public Health Center

## Treatment Summary for Active TB

Name		DOB
Address		Phone
City	State	Zip

**Start of Therapy Date** \_\_\_/\_\_\_/\_\_\_\_\_

**End of Therapy Date** \_\_\_/\_\_\_/\_\_\_\_\_

**Treatment Regimen**

Medication	Start Date	Stop Date	Start Date	Stop Date
<b>INH</b>				
<b>RIF</b>				
<b>PZA</b>				
<b>EMB</b>				

**Sputum Conversion**

Date of first positive culture \_\_\_/\_\_\_/\_\_\_\_\_ Date of first negative culture \_\_\_/\_\_\_/\_\_\_\_\_

**Susceptibilities**      Date of isolate \_\_\_/\_\_\_/\_\_\_\_\_

INH\_\_\_      RIF\_\_\_      PZA\_\_\_      EMB\_\_\_      STREP\_\_\_

Other\_\_\_\_\_

**PPD**    Date \_\_\_/\_\_\_/\_\_\_\_\_    Reading \_\_\_mm    **IGRA**    Date \_\_\_/\_\_\_/\_\_\_\_\_    Result \_\_\_\_\_

**CXR**    Date \_\_\_/\_\_\_/\_\_\_\_\_    Result \_\_\_\_\_

**CXR**    Date \_\_\_/\_\_\_/\_\_\_\_\_    Result \_\_\_\_\_

**CT**     Date \_\_\_/\_\_\_/\_\_\_\_\_    Result \_\_\_\_\_

\_\_\_\_\_      \_\_\_/\_\_\_/\_\_\_\_\_

Health Care Provider      Date

\_\_\_\_\_

Clinic      Phone



## Latent Tuberculosis Infection (LTBI) Treatment Report

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Village: \_\_\_\_\_

State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Please return form by: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Screened/treated immigrant or refugee**      **EDN Alien #:** \_\_\_\_\_

---

### SECTION 1:

**Date LTBI treatment started:**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Date LTBI treatment stopped:**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Number of doses taken:**

\_\_\_\_\_

**Completed:**

Yes    No

---

### SECTION 2:

**Regimen:**

- 9 months INH
- 6 months INH \_\_\_\_\_
- 4 months RIF \_\_\_\_\_
- 12 week INH / RPT
- Other \_\_\_\_\_

**Administered by:**

- DOT
- Self/parent

### SECTION 3:

**Reason LTBI treatment was discontinued before completion of full regimen:**

- a)  Discontinued by physician due to adverse reaction.      Date \_\_\_\_/\_\_\_\_/\_\_\_\_
- b)  Discontinued on medical advice for reason other than adverse reaction.      Date \_\_\_\_/\_\_\_\_/\_\_\_\_
- c)  Discontinued / switched to new LTBI treatment regimen  
Please specify: \_\_\_\_\_      Date \_\_\_\_/\_\_\_\_/\_\_\_\_
- d)  Discontinued by patient against medical advice.      Date \_\_\_\_/\_\_\_\_/\_\_\_\_
- e)  Patient lost to follow-up.  
Attempted outreach: letter(s) \_\_\_\_\_ phone call(s) \_\_\_\_\_      Date \_\_\_\_/\_\_\_\_/\_\_\_\_
- f)  Patient moved.  
New address: \_\_\_\_\_      Date \_\_\_\_/\_\_\_\_/\_\_\_\_
- g)  Window prophylaxis discontinued      Date \_\_\_\_/\_\_\_\_/\_\_\_\_
- h)  Patient developed active tuberculosis.      Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Return to:**  
Alaska TB Program  
3601 C Street, Suite 540  
Anchorage, AK 99503  
FAX: 907-563-7868

## Instructions for Completing *Latent Tuberculosis Infection Treatment Completion Report*

These reports are generated by the Alaska TB Program. They are sent to each public health nurse who has patients being treated for latent TB infection (LTBI). Because of the new short treatment regimens, reports will be generated approximately 1-3 months after patients should have completed therapy.

### **Section 1 – Date treatment of LTBI completed:**

If a patient has **completed the prescribed course** of treatment for LTBI, provide **the date treatment was completed**. Note that this section applies only to patients who have completed a full course of treatment.

#### Example #1

An adult patient starts isoniazid 1/01/00 and finishes taking 9 months of medication on 12/01/00. He has taken 9 months of medication in 11 months time. **Enter:** Date LTBI treatment completed = 12/01/00.

#### Example #2

A child starts isoniazid 1/01/00 and stops on 10/01/00. He missed 1 month refill and took a total of 8 months of medication in 9 months. He refuses to take another month of isoniazid. **Selection:** Since this child did not complete the 9 month treatment regimen for LTBI, a response from Section 3 must be chosen.

### **Section 2- Regimen for LTBI**

Mark the drug regimen the patient is taking. **Note:** The only recommended regimen for children is a 9 month course of isoniazid. For contacts on special regimens, select "Other" and indicate drug(s).

### **Section 3- Reason therapy for LTBI was discontinued before completion**

When selecting reason therapy for LTBI was discontinued, consider the following:

- a. "Discontinued by physician due to adverse reaction." Use for rash, hepatotoxicity, etc.
- b. "Discontinued on medical advice for reason other than adverse reaction." Use for pregnancy, extended travel or absence, etc.
- c. "Discontinued/switched to new LTBI treatment regimen." Use to indicate the stop date of the current regimen and planned switch to an alternate regimen. Used when patient fails the current regimen or must change regimens e.g. index case is INH resistant and infected contact being treated with INH.
- d. "Discontinued by patient against medical advice." Use when patient refuses to continue treatment.
- e. "Patient lost to follow-up." Indicate number of letters or calls made.
- f. "Patient moved." Please include forwarding address and the date the patient moved.
- g. "Window prophylaxis discontinued." Please indicate date window prophylaxis was discontinued.

Note: Effective 7/01/13, PPD is ONLY provided to State Public Health Centers, schools and school districts for required school TB screening



**Alaska Tuberculosis Program**

3601 C Street, Ste 586, Anchorage, AK 99503 Phone (907)334-0856 or 269-8029 Fax (907) 269-0472

**PPD ORDER FORM – Please fill in the following information**

Facility Name \_\_\_\_\_

PPD requested for  Public Health Center  
 School TB screening

→School Name \_\_\_\_\_ - Estimate # of students being tested \_\_\_\_\_

Other, explain \_\_\_\_\_ EPI Approval \_\_\_\_\_

Name and Title of Licensed Medical Provider \_\_\_\_\_

Name of Designated Facility Person of Contact \_\_\_\_\_

Physical Address (NO P.O. Boxes) \_\_\_\_\_

Mailing Address (if different from physical) \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_ E-mail \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Special Delivery Instructions \_\_\_\_\_

\*\*\*\*\*

Please allow up to 3 weeks for processing. For larger requests or anticipated events that may require additional PPD, please notify the SOE TB Room to verify available inventory. Staff will notify person of contact once the order is ready to be shipped.

- **Anchorage/Mat-Su area providers will be able to pick up their order at the SOE TB Room.**
- **All other orders will be shipped via Goldstreak, courier service, or other prearranged methods.**
- ***Please be responsible in maintaining the product in a monitored refrigerator and proper cold chain maintenance during off-site travel clinics.***
- **Report all temperature excursions promptly to the SOE TB Room at (907) 334-0856.**

\*\*\*\*\*

NEED BY DATE:	BALANCE ON -HAND:	ORDER QUANTITY:	For Drug Room Use
	1ml vials: _____	1ml vials: _____	QTY: _____ LOT: _____ EXP: _____
	5ml vials: _____	5ml vials: _____	QTY: _____ LOT: _____ EXP: _____

***NOTE: 1mL vial contains 10 doses/tests and 5mL contains 50 doses/tests. A vial of Tubersol which has been entered and in use for 30 days should be discarded.***

[Tubersol storage requirements](#) - **Store at 2° to 8°C (35° to 46°F). Do not freeze.**



**Alaska TB Program  
Section of Epidemiology  
3601 C Street, Suite 540  
Anchorage, AK 99503  
Phone (907) 269-8000 , Fax (907) 563-7868**

**REFERRAL AND AUTHORIZATION FOR TB SCREENING AND FOLLOW-UP SERVICES**

**DATE:** \_\_\_\_\_

**PROVIDER/FACILITY:** \_\_\_\_\_

**CLIENT:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**REASON FOR EVALUATION (check all that apply):**

- |  |   |
|--|---|
| <input type="checkbox"/> Immigration screen          | <input type="checkbox"/> Contact investigation          |
| <input type="checkbox"/> Pre-employment screen       | <input type="checkbox"/> Rule out active disease        |
| <input type="checkbox"/> College/school entry screen | <input type="checkbox"/> Other (please describe): _____ |

**REASON FOR AUTHORIZATION:**

- No insurance
- High deductible (**contact TB Program for approval**-services primarily for persons without *any* insurance)

**SERVICE(S) REQUESTED:**

<input type="checkbox"/> CHEST X-RAY (CPT 71045) Single View	Authorization #: _____ reimbursement up to \$125 allowed
<input type="checkbox"/> HEPATIC PANEL (CPT 80076)	Authorization #: _____ reimbursement up to \$110 allowed
<input type="checkbox"/> IGRA: Q Gold (CPT 86480) T Spot (CPT 86481) QFT-Plus (CPT 36970)	Authorization #: _____ reimbursement up to \$110 allowed
<input type="checkbox"/> VENIPUNCTURE (CPT 36415)	Authorization #: _____ reimbursement up to \$40 allowed
<input type="checkbox"/> Other _____	Authorization #: _____

**NOTE: Reimbursement is ONLY available for the services authorized above. See page 2 for additional information.**

**PHYSICIAN:** Dr. Joseph McLaughlin, State of Alaska Section of Epidemiology, NPI: 1245523257

**SERVICE(S) REQUESTED BY:** \_\_\_\_\_, PHN

FAX REPORT/RESULTS TO: \_\_\_\_\_

MAIL X-RAY CD/FILM TO: \_\_\_\_\_

**Please send invoice and this authorization to:**

Attn: LoRena Carlock,  
Alaska DHSS, DPH, Section of Epidemiology/TB Program  
3601 C Street, Ste. 540  
Anchorage, AK 99503 **907-269-8000**

**NOTE:**

The Alaska TB Program is the payer of last resort and authorizes payment not to exceed the listed amounts for the targeted diagnostic services listed on this form. To qualify for payment through the Alaska TB Program, patients must be *without* health insurance coverage for the requested services. Only single view chest x-rays, hepatic panels and venipuncture can be authorized by public health nurses without prior approval from the Alaska TB Program. The Alaska TB Program *does not* provide payment for radiologic interpretation of chest x-rays (71010-26); all films are sent to our contract radiologist for review and interpretation.

LFTs and venipuncture may be authorized for high risk (HIV +, liver disease, alcohol abuse, etc.) or symptomatic patients who are being treated for latent tuberculosis infection or active tuberculosis. The Alaska TB Program **will not** authorize payment for routine monitoring of LFTs in low risk individuals.

When patients have insurance coverage, the Alaska TB Program should not be balance billed and will not pay for costs that exceed payments received from the patient's third party payer.

# Sputum Collection Guidelines

## Why is a Sputum Test Necessary?

- Your doctor needs you to collect a sputum sample to test for tuberculosis (TB) in your lungs. Checking your sputum is the best way to find out if you have TB disease or to see if your treatment is working.
- To collect an acceptable sample you need to cough up sputum from deep inside of your lungs as soon as you wake up in the morning. The lab needs at least 5 mL of sputum.

## How to Collect a Sputum Sample

1. The TB sputum tube must not be opened until you are ready to use it. DO NOT REMOVE preservative (white powder) from the tube.
2. As soon as you wake up in the morning, before you eat or drink, rinse your mouth with WATER.
3. Take a very deep breath and hold air for 5 seconds. Slowly breathe out. Take another deep breath and cough hard until some sputum comes up into your mouth.
4. Spit the sputum into the TB tube.
5. Keep collecting until the sputum reaches the 5 mL line on the TB tube.
6. Screw the orange cap on the tube tightly so it doesn't leak.
7. Wash and dry the outside of the TB tube.
8. Write your NAME, BIRTH DATE, and the DATE/TIME you collected the sputum on the tube and lab form.
9. Put the tube into the bag provided.
10. Deliver sample (s) to your Community Health Aide, doctor(s) office, or PHN AS SOON AS POSSIBLE. (*Samples must be received at the Anchorage laboratory for testing within 10 days of collection.*)
11. If you need to collect three TB samples, collect them in the morning on three different days, unless you are told otherwise. Keep in a cool place until all are collected. Do not freeze.

**Alaska State Public Health Laboratory:** 5455 Dr. Martin Luther King Jr. Ave., Anchorage, AK 99507 Phone: (907) 334-2100 Fax: (907) 334-2161

**Alaska Tuberculosis Program:** For more information about TB call the Section of Epidemiology at (907) 269-8000 or visit their website at: <http://dhss.alaska.gov/dph/Epi/id/Pages/tb.aspx>.

## TB Case Management Form

**Client Name:** \_\_\_\_\_  
**Sex:**  M  F      **DOB:** \_\_\_/\_\_\_/\_\_\_  
**Race:**  AKN/AI  Asian  Black  White  HI/PI  
**Ethnicity:**  Hispanic  Non-Hispanic  
**Health Care Provider** \_\_\_\_\_  
**Provider Phone #:** \_\_\_\_\_

**Village:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Type of TB:**  Pulm  Extra-Pulm \_\_\_\_\_  
**Previous Dx of TB:**  Yes  No Year \_\_\_\_\_  
**Previous Rx for LTBI:**  Yes  No Year \_\_\_\_\_  
**Birth Country** \_\_\_\_\_ **# of yrs in US** \_\_\_\_\_  
**Occupation:** \_\_\_\_\_  Alive  Dead at DX?

**TST (at TB diagnosis):** Date \_\_\_/\_\_\_/\_\_\_ Result \_\_\_mm  Positive  Negative  Not done  Unknown  
**Previous TST:** Date \_\_\_/\_\_\_/\_\_\_ Result \_\_\_mm **IGRA** Date \_\_\_/\_\_\_/\_\_\_ Result  Pos  Neg  Equiv

**Symptoms:**  Asymptomatic  
 Cough  Productive cough  Sweats  Weight Loss  Fatigue  
 Chest Pain  Other \_\_\_\_\_  
**Reason Evaluated for TB:**  SX  abn. CXR  CI  targeted testing  HCW  Job  Immigration  Inc. lab result  other

**Chest x-ray:** Date \_\_\_/\_\_\_/\_\_\_  Normal  Abnormal  Not done  Unknown  
 Findings \_\_\_\_\_  Cavitary  Non-cav / consistent with TB  Miliary TB  
**CT/Chest Imaging:** Date \_\_\_/\_\_\_/\_\_\_  Normal  Abnormal  Not done  Unknown  
 Findings \_\_\_\_\_  Cavitary  Non-cav / consistent with TB  Miliary TB

**Sputum Results:**  Not collected  Unknown      **Sputum Conversion?**  Yes  N

Initial Sputum Results				Conversion Sputum Results			
Date	Smear (0 - 4+)	TB NAAT		Culture	Date	Smear (0 - 4+)	Culture
		GeneXpert	ASPHL PCR				
1.					1.		
2.					2.		
3.					3.		

**Other specimen AFB smear and culture results:**  Not done  Unknown

Date	Specimen Site	Micro Exam (Pos, Neg, Not done, Unk)	Culture (Pos, Neg, Not done, Unk)
1.			
2.			

**Therapy:**  None  Why? \_\_\_\_\_ TX extended >12 mos for  RIF R  Adv RXN  Non-adh  Failure  Other \_\_\_\_\_

Medication	Start Date	Stop Date	Start Date	Stop Date	Medication	Start Date	Stop Date	Start Date	Stop Date
INH									
Rifampin									
EMB									
PZA									

**Drug susceptibility:** (S=sensitive, R=resistant, N=not done, U=unknown)

Coll. date: \_\_\_/\_\_\_/\_\_\_ Report date: \_\_\_/\_\_\_/\_\_\_ INH \_\_\_ RIF \_\_\_ PZA \_\_\_ EMB \_\_\_ STREP \_\_\_  
 Coll. date: \_\_\_/\_\_\_/\_\_\_ Report date: \_\_\_/\_\_\_/\_\_\_ ( ) \_\_\_ ( ) \_\_\_ ( ) \_\_\_ ( ) \_\_\_ ( ) \_\_\_

Homeless:  Yes  No  Unk  
 Corrections resident:  Yes  No  Unk  
 Longterm care resident:  Yes  No  Unk  
 Injecting drug use:  Yes  No  Unk  
 Non-injecting drug use:  Yes  No  Unk  
 Excess alcohol use:  Yes  No  Unk  
 Diabetes:  Yes  No  Unk

HIV testing: Date \_\_\_/\_\_\_/\_\_\_  Neg  Pos  Indeterminate  
 Refused  Not offered

Smokes:  Yes  No \_\_\_\_\_ Amount: \_\_\_\_\_

**Contact Investigation Forms**

Initial  Yes  No  Unk  
 Final  Yes  No  Unk

**Infectious Period Start Date** \_\_\_/\_\_\_/\_\_\_

**Infectious Period End Date** \_\_\_/\_\_\_/\_\_\_

DOT Calendars: (X=in chart) J F M A M J J A S O N D J F M A M J

**EPI Case Manager** \_\_\_\_\_ **PHN Case Manager** \_\_\_\_\_

**Date of treatment completion:** \_\_\_/\_\_\_/\_\_\_ **Date case closed** \_\_\_/\_\_\_/\_\_\_ **Initials** \_\_\_\_\_



Alaska TB Program  
 Section of Epidemiology  
 3601 C Street, Suite 540  
 Anchorage, AK 99503  
 (907) 269-8000 (phone) (907) 563-7868 (fax)

**TB Case Management Information Request**

To: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

From: \_\_\_\_\_

Patient: \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Review of our records indicates that we are in need of the following:**

- \_\_\_\_ Occupation \_\_\_\_\_
- \_\_\_\_ Race: White  Black  Native  Asian
- \_\_\_\_ Ethnicity: Hispanic  Non-Hispanic
- \_\_\_\_ Birth country: \_\_\_\_\_ Arrival date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- \_\_\_\_ TST: Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Results (mm) \_\_\_\_\_
- \_\_\_\_ IGRA: Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Results:  pos.  neg.  indeterminate
- \_\_\_\_ Primary provider's initial chart notes / H & P
- \_\_\_\_ CXR Report(s)
- \_\_\_\_ CT / MRI Report(s)
- \_\_\_\_ Conversion sputa
- \_\_\_\_ HIV status: Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Results \_\_\_\_\_ Not Offered  Refused
- \_\_\_\_ History of LTBI? Yes  No  Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- \_\_\_\_ History of Active TB? Yes  No  Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- \_\_\_\_ Homeless within last year? Yes  No
- \_\_\_\_ In correctional facility at diagnosis? Yes  No
- \_\_\_\_ In long term care facility at diagnosis? Yes  No
- \_\_\_\_ Excess alcohol within past year? Yes  No
- \_\_\_\_ Non-injecting drug use within past year? Yes  No
- \_\_\_\_ Injecting drug use within past year? Yes  No
- \_\_\_\_ Smokes cigarettes? Yes  No  Packs/day \_\_\_\_\_
- \_\_\_\_ Diabetes? Yes  No
- \_\_\_\_ Initial *Contact Investigation Form*
- \_\_\_\_ Final *Contact Investigation Form*
- \_\_\_\_ DOT Calendars: J F M A M J J A S O N D
- \_\_\_\_ End of therapy date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- \_\_\_\_ Other \_\_\_\_\_

**THANK YOU**

## Tuberculosis Discharge Planning Checklist

**Patient Name:** \_\_\_\_\_ **Patient DOB:** \_\_\_\_\_ **Patient Phone#:** \_\_\_\_\_  
**Residence:** \_\_\_\_\_ **Discharge location (if different):** \_\_\_\_\_  
**Provider responsible for ongoing treatment:** \_\_\_\_\_

*Continuity of care of Tuberculosis patients is critical. Discharge planning should involve a PHN case manager who will be responsible for coordinating daily follow-up. All patients need a medical home and established monitoring plan prior to discharge.*

**TB is a reportable condition: Report all suspect or confirmed cases to the Alaska TB Program at 907-269-8000.**

### **Isolation needs:**

- Discharge potentially infectious patients only to appropriate, safe out-of-hospital settings.
- Reinforce the need to stay home until public health and the clinician determine that isolation is no longer required.
- Do not** discharge infectious patients to congregate settings such as nursing homes, assisted living facilities, shelters, or correctional facilities (unless they will be in an airborne infection isolation room).

### **Medications:**

- Ensure patient is tolerating appropriate anti-TB medication regimen, given at the same time each day.
- Ensure that PHN case manager has a directly observed therapy (DOT) plan in place prior to discharge.
- At discharge, supply the patient with 1-2 weeks of medications to avoid treatment interruptions.

### **Educate the patient:**

- Reinforce infection control measures to prevent transmission to others (i.e. remain in negative pressure room, avoid contact with unexposed persons, cover mouth when coughing or sneezing, etc.).
- Collaborate with the PHN case manager to provide information about TB transmission, contact investigation, treatment, adverse reactions, DOT, adherence, expected length of therapy, and roles.
- Inform patient that PHN case manager will contact them to arrange follow-up and perform contact investigations. A PHN may call or visit the patient and initiate contact investigation during hospitalization.

### **Discharge Plan: finalize with the PHN case manager at least 2 business days before discharge:**

- Be prepared to provide/fax the following information: face sheet, H&P, TB medication administration records (MAR), script for TB meds, sputa and pathology results, labs (HIV, CBC, creatinine, LFTs), chest x-ray and CT reports, TST or IGRA results, estimated discharge date, and date of follow-up appointment.
- Assess patient for barriers that may impact treatment (i.e. substance abuse, no access to care/insurance, beliefs, co-morbidities, housing, etc.), and collaborate with PHN case manager to address them.

### **Travel:**

- Patients with suspected or confirmed TB may not be able to travel on public conveyances -airplanes, busses, ferries or shuttles. Contact the Alaska TB Program for clearance.**

**Notes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PHN case manager:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Alaska TB Program contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_





# ***TB/LTBI Prescription and Medication Request Guidelines***

## **Background:**

The State participates in the [Federal 340B Drug Pricing Program](#) which allows the TB-program to purchase tuberculosis medications at a substantial discount. Only facilities that are registered on the 340B database are eligible to receive medications purchased through the discount program. The medications can only be dispensed or administered to an '[eligible patient](#)' as defined by Health Resources and Service Administration (HRSA). All medications provided by the State TB program must be documented regarding their utilization and the records must be readily retrievable for auditing purposes. The TB Room staff will oversee 340B compliance issues and perform self-audits on the covered entities.

## **Medication Ordering Process:**

- Complete the TB/LTBI Medication Request Form and submit to the EPI-TB Team for review **(907-563-7868)**. Once review is completed it will then be forwarded to the TB Room for processing.
- All changes in therapy require that a new *TB/LTBI Prescription and Medication Request* be completed and submitted for processing. New orders will supersede all prior medication orders and older medication orders will be discontinued and will not be available for refilling.
  - Fill out return medication form and send back discontinued medications to TB Room for proper processing.
- Prescribers that do not have an '**Entity-Prescriber Relationship**' with the covered entity (See Table 1 for definition) need to either use the updated medication request form OR sign the provider agreement form.
  - Provider agreement form can be requested from the TB Room staff
- Expedited or overnight shipping (Goldstreak) must be authorized by the EPI Team.

## **Review for Drug Interactions:**

- Pharmacist will review client's medication list with submitted TB-drug therapy to provide:
  - Consultation for drug interactions
  - Drug interaction report (recommended course of action/monitoring)

## **Medication Refill Process:**

- Only therapies that have refills remaining are eligible to receive "refill reminders" from the TB Room. Fax reminders are set to anticipate refills within two weeks prior to running out of medication based upon the last refill date. **Please review for accuracy as this helps prevent unnecessary work in filling and returning of medications.** Please add any comments to discontinue, hold, or therapy changes to inform TB Room of possible therapy modifications.
- Refills can be requested early and for special circumstances. Contact the TB Room to make arrangements or add onto the weekly refill reminder.
- Drug orders are only valid for one-year from the original order date.

# ***TB/LTBI Prescription and Medication Request Guidelines***

## **Medication Storage and Handling:**

- All medications should be stored **securely** under controlled room temperature conditions as defined by the [USP guidelines](#) unless otherwise specified by the manufacturer.
- Only authorized personal should have access to medications and kept under a secure storage area.
- Dose Packs are **NOT** child proof and are required to be stored in a secure area (**keep out of reach of children**).
- Expiration dates are only valid if products have been stored within the temperature limits set forth by the manufacturer.
- Do not discard medications unless instructed by the TB Room. Fill out return medication form and send back to TB Room for proper processing.

## **Miscellaneous:**

- Compounding liquid forms of medications takes extra time and can be ordered as needed.
- State and Federal laws require that both Drug Monographs and or Medications Guides be given to the client with all new medication orders for their review. It is the responsibility of the facility to insure these documents are dispensed to their clients with their medications.
- Stock Medications request will be addressed in the policy and procedures manual.
- The Drug room is licensed through the Board of Pharmacy. Ordering and labeling of medications follow the [Alaska Board of Pharmacy](#) Statutes and Regulations.

## **TB Room Contacts:**

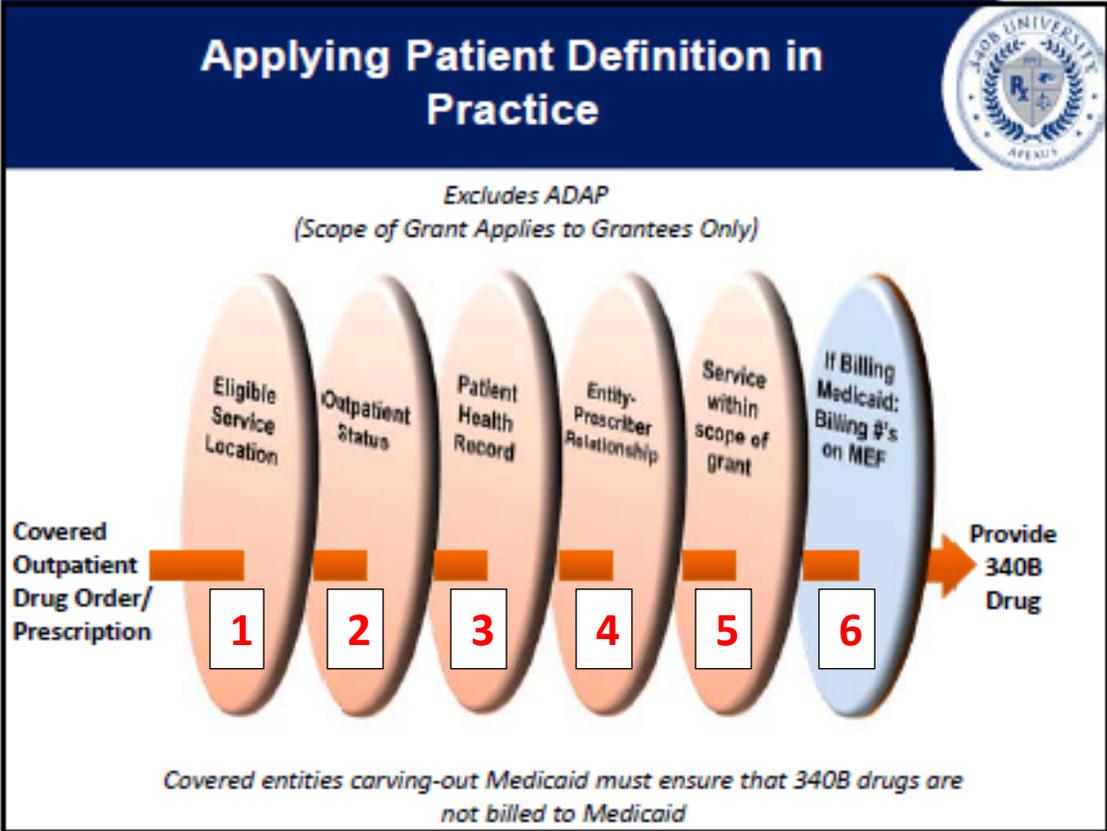
- |                           |  |              |
|---------------------------|--|--------------|
| • C.J. Kim, Pharmacist    | <a href="mailto:cj.kim@alaska.gov">cj.kim@alaska.gov</a>           | 907-269-8029 |
| • Robin Laird, Technician | <a href="mailto:robin.laird@alaska.gov">robin.laird@alaska.gov</a> | 907-334-0856 |
| • TB Room Fax number      |  | 907-269-0472 |

Please remove all HIPAA related items when using regular email, DSM is available to transmit HIPAA sensitive information.

# TB/LTBI Prescription and Medication Request Guidelines

Table 1 briefly explains the steps that each TB-drug order must be scrutinized for before dispensing or administering 340B purchased medications.

**Table 1**



## ***TB/LTBI Prescription and Medication Request Guidelines***

**Table 1 explanation:**

Filter number	Definition	Additional Comments
1- Eligible service location	Covered entity is registered on the 340B database	Ineligible service location either is not on the 340B database or does not qualify to be registered
2-Outpatient Status	Drug is intended for outpatient use	Violation and possible audit finding if used for inpatient supply
3-Patient Health Record	Covered entity is recording/documenting the care provided, medications administered/dispensed	Self-audits will be initiated to help assist in maintaining drug accountability
4-Entity Prescriber Relationship	<p>3-Part Definition:</p> <ul style="list-style-type: none"> <li>· the covered entity has established a relationship with the individual, such that the covered entity maintains records of the individual's health care; <b>and</b></li> <li>· the individual receives health care services from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g. referral for consultation) such that responsibility for the care provided remains with the covered entity; <b>and</b></li> <li>· the individual receives a health care service or range of services from the covered entity which is consistent with the service or range of services for which grant funding or Federally-qualified health center look-alike status has been provided to the entity. Disproportionate share hospitals are exempt from this requirement.</li> </ul>	In satisfying this definition, the new TB-Medication Request form OR Provider Agreement form must be used. The Drug Room will keep these records on file.
5-Service within scope of grant	<p>Grant Title: "TB Elimination and Laboratory Program Cooperative Agreement"</p> <ul style="list-style-type: none"> <li>· Services are outlined in the scope of the grant and also provides eligibility to participate in the Federal 340B Drug Pricing Program</li> </ul>	Eligible service locations (Covered entities) have either direct funding OR 317 In-Kind funding
6-Billing Medicaid	Prevention of duplication discounts. All covered entities have been registered as they are NOT billing Medicaid for drug reimbursement.	Manufacturers are prohibited from providing a discounted 340B price and a Medicaid drug rebate for the same drug. Covered entities must accurately report how they bill Medicaid drugs on the Medicaid Exclusion File, as mandated by 42 USC 256b(a)(5)(A)(i). The Drug Room and any facility receiving 340B purchased medications should not be billing Medicaid for drug reimbursement.

**ALASKA TUBERCULOSIS PROGRAM  
TUBERCULOSIS PRESCRIPTION / MEDICATION REQUEST FORM  
FAX COMPLETED FORM TO 907-563-7868 (INCOMPLETE FORMS MAY DELAY PROCESSING)**

Date Needed at Facility: \_\_\_\_\_  OR  next delivery cycle \*\*\*Expedited Shipping requires Epi approval, Overnight Shipping Approved by: \_\_\_\_\_

Patient Last Name: \_\_\_\_\_ Patient First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Weight: \_\_\_\_\_ kg HR# \_\_\_\_\_  MALE  FEMALE and  PREGNANT OR  BREASTFEEDING (CHECK ONLY IF APPLICABLE)

No Known Allergies OR List Allergies: \_\_\_\_\_ Projected Start Date: \_\_\_\_\_

Medications taking (including OTC's): \_\_\_\_\_

- New Medication Request  - Modification of Existing Medication Order  - English Medication Info Sheet or other: \_\_\_\_\_

Doses given from STOCK: \_\_\_\_\_ Dispense in:  Bottles OR  Unit Dose Packs (NOT CHILD PROOF)

Provider Prescription

PT NAME: \_\_\_\_\_ ADDRESS/CITY: \_\_\_\_\_

Drug Order(s)	Dose	Route	Frequency	Doses Requested for Therapy
<input type="checkbox"/> ISONIAZID	_____ mg	_____	<input type="checkbox"/> 7X wk <input type="checkbox"/> 5X wk <input type="checkbox"/> 3X wk <input type="checkbox"/> 2X wk <input type="checkbox"/> Wkly	_____ x _____ Doses
<input type="checkbox"/> RIFAMPIN	_____ mg	_____	<input type="checkbox"/> 7X wk <input type="checkbox"/> 5X wk <input type="checkbox"/> 3X wk <input type="checkbox"/> 2X wk	_____ x _____ Doses
<input type="checkbox"/> PYRAZINAMIDE	_____ mg	_____	<input type="checkbox"/> 7X wk <input type="checkbox"/> 5X wk	_____ x _____ Doses
<input type="checkbox"/> ETHAMBUTOL	_____ mg	_____	<input type="checkbox"/> 7X wk <input type="checkbox"/> 5X wk	_____ x _____ Doses
<input type="checkbox"/> B-6 PYRIDOXINE	_____ mg	_____	<input type="checkbox"/> 7X wk <input type="checkbox"/> 5X wk <input type="checkbox"/> 3X wk <input type="checkbox"/> 2X wk <input type="checkbox"/> Wkly	_____ x _____ Doses
<input type="checkbox"/> RIFAPENTINE	_____ mg	_____		<input type="checkbox"/> Wkly _____ x _____ Doses
<input type="checkbox"/> MOXIFLOXACIN	_____ mg	_____	<input type="checkbox"/> 7X wk <input type="checkbox"/> 5X wk	_____ x _____ Doses
<input type="checkbox"/> _____	_____ mg	_____		_____ x _____ Doses

Notation / Special Request: \_\_\_\_\_

\*Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*Provider Printed Name: \_\_\_\_\_ Provider City: \_\_\_\_\_

Provider Phone: \_\_\_\_\_ Provider Fax: \_\_\_\_\_

Are these medications to treat:      Active disease      LTBI      Window prophylaxis

Mail to: \_\_\_\_\_

PHN Requesting Medication / Point of Contact: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Date of Request: \_\_\_\_\_

For Alaska TB Program use

AK TB Program Review by: \_\_\_\_\_ Date: \_\_\_\_\_ Faxed to Drug Room by: \_\_\_\_\_ Date: \_\_\_\_\_

Form in compliance with 12 AAC 52.460 Prescription Drug Order Information

*\*This form also: "Provides Health Care Under Contractual Arrangements" as defined by HRSA with the prescribing provider and the 340B Covered Entity. Providers agree to use standard and approved regimens as referenced in the AK TB Manual to treat individuals for suspected or confirmed tuberculosis/LTBI. In special situations and after consultation with the Alaska TB program, other regimens may be approved if clinically indicated.*

**Table 1: First-line anti-tuberculosis drugs and dosing for adults and children\***  
*For drug dosing recommendations for active disease in pediatrics refer to table 3.*

Drug	Preparation	Adult/Child	Daily	Daily Max Dosage	Once-weekly (1x/week)	Once-weekly Max Dosage	Twice-weekly (2x/week)	Twice-weekly Max Dosage	Thrice-weekly (3x/week)	Thrice-weekly Max Dosage
Isoniazid	Tablets (50, 100, 300 mg); Elixir (50 mg/5 ml); Aqueous IV/IM solution (100 mg/ml) <sup>±</sup>	Adults	5 mg/kg	300 mg	15 mg/kg	900 mg	15 mg/kg	900	15 mg/kg	900
		Children	10-15 mg/kg	300 mg	---	---	20-30 mg/kg	900	---†	900
Rifampin	Capsule (150, 300 mg); suspend powder for PO; Aqueous IV solution	Adults**	10 mg/kg	600 mg	---	---	10 mg/kg	600	10 mg/kg	600
		Children <sup>#</sup>	children ≥ 2 years 15-20mg/kg children < 2 years 20-30 mg/kg	600 mg	---	---	10-20 mg/kg	600	---†	600
Rifabutin <sup>††</sup>	Capsule (150 mg)	Adults**	5 mg/kg	300 mg	---	---	Not recommended	---	Not recommended	---
		Children	Appropriate dosing for children is unknown. Estimated at 5mg/kg.							
Pyrazinamide	Tablet (500 mg)	Adults	40-55 kg → 1,000 mg 56-75 kg → 1,500 mg 76-90 kg → 2,000 mg	---	---	---	40-55 kg → 2,000 mg 56-75 kg → 3,000 mg 76-90 kg → 4,000 mg	---	40-55 kg → 1,500 mg 56-75 kg → 2,500 mg 76-90 kg → 3,000 mg	---
		Children	35 (30-40) mg/kg	---	---	---	50 mg/kg	---	---†	---
Ethambutol	Tablet (100 and 400 mg)	Adults	40-55 kg → 800 mg 56-75 kg → 1,200 mg 76-90 kg → 1,600 mg	---	---	---	40-55 kg → 2,000 mg 56-75 kg → 2,800 mg 76-90 kg → 4,000 mg	---	40-55 kg → 1,200 mg 56-75 kg → 2,000 mg 76-90 kg → 2,400 mg	---
		Children	20 (15-25) mg/kg	---	---	---	50 mg/kg	---	---†	---
<b>Isoniazid and Rifapentine (3HP) Once Weekly for 12 Weeks, for Persons Aged ≥2 Years for treatment of LTBI</b>										
	<b>Preparation</b>	<b>Adult/Child</b>	<b>Once Weekly</b>	<b>Max Dose</b>						
Isoniazid	Tablet (100 and 300 mg)	≥ 12 years of age	15 mg/kg rounded up to nearest 50/100 mg	900						
		2-11 years of age	25mg/kg rounded up to the nearest 50/100 mg	900						
Rifapentine	Tablet (150 mg)		10.0-14.0 kg → 300 mg 14.1-25.0 kg → 450 mg 25.1-32.0 kg → 600 mg 32.1-49.9 kg → 750 mg ≥ 50kg → 900 mg	900						

**Daily or thrice weekly dosing is preferred.**

\*Dosing based on actual weight is acceptable in patients who are not obese. For obese patients (>20% above ideal body weight [IBW]), dosing based on IBW may be preferred for initial doses. Some clinicians prefer a modified IBW (IBW + [0.40 x (actual weight – IBW)]) as is done for initial aminoglycoside doses. Because tuberculosis drug dosing for obese patients has not been established, therapeutic drug monitoring may be considered for such patients

† For purpose of this document, adult dosing begins at age 15 years or at a weight of >40 kg in younger children. The optimal doses for thrice-weekly therapy in children and adolescents have not been established. Some experts use in adolescents the same doses as recommended for adults, and for younger children the same doses as recommended for twice-weekly therapy .

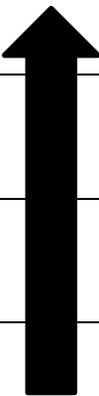
±Pyridoxine (vitamin B6), 20-50 mg/day, is given with INH to all persons at risk of neuropathy (eg, pregnant women; breastfeeding infants; persons with HIV; patients with diabetes, alcoholism. Malnutrition, or chronic renal failure; patients with advanced age.) For patients with peripheral neuropathy, experts recommend increasing pyridoxine dose to 100 mg/d.

\*\* Higher doses of rifampin, currently as high as 35 mg/kg, are being studied in clinical trials/

†† Rifabutin dose may need to be adjusted when used with protease inhibitors or nonnucleoside reverse transcriptase inhibitors.

⌘ American Academy of Pediatrics. [Tuberculosis]. In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. Red Book: 2018-2021 Report of the Committee on Infectious Diseases. 31st ed. Itasca, IL: American Academy of Pediatrics;2018 [pg. 842]

**DRUG REGIMENS FOR MICROBIOLOGICALLY CONFIRMED PULMONARY TUBERCULOSIS CAUSED BY DRUG-SUSCEPTIBLE ORGANISMS**

Intensive Phase			Continuation Phase				Regimen Effectiveness
Regimen	Drug <sup>a</sup>	Interval and Dose <sup>b</sup> (Minimum Duration)	Drugs	Interval and Dose <sup>b,c</sup> (minimum Duration)	Range of Total Doses	Comments <sup>c,d</sup>	
1	INH RIF PZA EMB	7 d/wk for 56 doses (8 wk), or 5 d/wk for 40 doses (8 wk)	INH RIF	7 d/wk for 126 doses (18 wk), or 5 d/wk for 90 doses (18 wk)	182-130	This is the preferred regimen for patients with newly diagnosed pulmonary tuberculosis	
2	INH RIF PZA EMB	7 d/wk for 56 doses (8 wk), or 5 d/wk for 40 doses (8 wk)	INH RIF	3 times weekly for 54 doses (18 wk)	110-94	Preferred alternative regimen in situations in which more frequent DOT during continuation phase is difficult to achieve	
3	INH RIF PZA EMB	3 times weekly for 24 doses (8 wk)	INH RIF	3 times weekly for 54 doses (18 wk)	78	Use regimen with caution in patients with HIV and/or cavitary disease. Missed doses can lead to treatment failure, relapse, and acquired drug resistance	
4	INH RIF PZA EMB	7 d/wk for 14 doses then twice weekly for 12 doses <sup>e</sup>	INH RIF	Twice weekly for 36 doses (18 wk)	62	Do not use twice-weekly regimens in HIV-infected patients or patients with smear-positive and/or cavitary disease. If doses are missed, then therapy is equivalent to once weekly, which is inferior	

Source: ATS, CDC, IDSA. Treatment of Drug-Susceptible Tuberculosis. Clinical Infectious Diseases 2016; 63(7):147-95.

Abbreviations: DOT: directly observer therapy; EMB: ethambutol; HIV: human immunodeficiency virus; INH: isoniazid; PZA: pyrazinamide; RIF: rifampin

<sup>a</sup> Other combinations may be appropriate in certain circumstance; additional details are provided in the section “recommended Treatment Regimens.”

<sup>b</sup> When DOT is used, drugs may be given 5 days per week and the necessary number of doses adjusted accordingly. Although there are no studies that compare 5 with 7 daily doses, extensive experience indicates this would be an effective practice. DOT should be used when drugs are administered <7 days per week.

<sup>c</sup> Based on expert opinion, patients with cavitation on initial chest radiograph and positive cultures at completion of 2 months of therapy should receive a 7-month (31-week) continuation phase

<sup>d</sup> Pyridoxine (vitamin B6), 25-50 mg/day, is given with INH total persons at risk of neuropathy(eg, pregnant women; breastfeeding infants; persons with HIV; patients with diabetes, alcoholism, malnutrition, or chronic renal failure; or patients with advance age). For patients with peripheral neuropathy, experts recommend increasing pyridoxine dose to 100mg/day.

<sup>e</sup> Alternatively, some US tuberculosis control programs have administered intensive-phase regimens 5 days per week for 15 doses (3 weeks), then twice weekly for 12 doses.

### Table 3. Pediatric Drug Dosing for Active Disease

TABLE 2. ISONIAZID

Child's weight		Daily isoniazid dose 10-15 mg/kg/dose		
KILOGRAMS	POUNDS	MILLIGRAMS	100 mg TABS	300 mg TABS
3-5	6.6-11	50 mg	1/2	0
5-7.5	11-16.4	75 mg	3/4	0
7.5-10	16.5-22	100 mg	1	0
10-15	22-33	150 mg	0	1/2
15-20	33-44	200 mg	2	0
Over 20	Over 44	300 mg	0	1

**Maximum daily isoniazid dose is 300 mg**

TABLE 3. RIFAMPIN updated 9-25-19

Child's weight		Daily rifampin dose			
KILOGRAMS	POUNDS	MILLIGRAMS	150 mg CAP	300 mg CAP	mg/kg/dose
< 3.3 over 28 days	7.3	75 mg	1/2	0	22.7+
3.3-5	7.3-11	100 mg	2/3	0	20-30
5-7.5	11-16.5	150 mg	1	0	20-30
7.5-11	16.5-24	225 mg	1.5	0	20-30
11-15	24-33	300 mg	0	1	20-27
15-20	33-44	375 mg	1/2	1	19-25
20-27	44-59	450 mg	1	1	17-22
Over 27	Over 59	600 mg	0	2	< 22

**Maximum daily rifampin dose is currently 600 mg (higher adult doses are being evaluated)**

Recent studies suggest that young children metabolize rifampin more quickly and that doses of rifampin used in the past have not been achieving adult serum levels. Hence, the 2018 AAP Red Book notes: Many experts recommend using a daily rifampin dose of 20-30 mg/kg/day for infants and toddlers, and for serious forms of tuberculosis such as meningitis and disseminated disease. Neonates (<28 days of age) should receive rifampin 10 mg/kg/day

When isoniazid in a dosage exceeding 10/mg/kg/dose is used in combination with rifampin, the incidence of hepatotoxic effects may be increased.

TABLE 4. PYRAZINAMIDE revised 6/7/16

Child's weight		Daily pyrazinamide dose 30-40 mg/kg/dose	
KILOGRAMS	POUNDS	MILLIGRAMS	500 mg TABS
3-4.2	6.6-9.2	125 mg	1/4
4.3-6.2	9.4-13.6	187.5 mg	3/8
6.3-8.9	14-20	250 mg	1/2
9-12.5	20-27.5	375 mg	3/4
12.6-18	27.7-40	500 mg	1
18.1-25	40-55	750 mg	1 1/2
25.1-33.3	55-73	1000 mg	2
33.4-41.5	73-91	1250 mg	2 1/2
41.6-50	91-110	1500 mg	3
50.1 & over	Over 110	2000 mg	4

Dose obese children on lean body weight

**Maximum daily pyrazinamide dose is 2 grams**

TABLE 5. ETHAMBUTOL updated 7-26-18 to align with 2018 AAP Red Book

Child's weight		Daily ethambutol dose 15-25 mg/kg/dose		
KILOGRAMS	POUNDS	MILLIGRAMS	100 mg TABS	400 mg TABS
4-6	9-13	100 mg	1	0
6-8	14-17	150 mg	1 1/2	0
8-12.5	18-27	200 mg	2	0
12.5-17.5	28-38	300 mg	3	0
17.5-22.5	39-49	400 mg	0	1
22.5-27.5	50-60	500 mg	1	1
27.5-32.5	61-71	600 mg	2	1
32.5-37.5	72-82	700 mg	3	1
37.5-55	83-121	800 mg	0	2
56-75	123-165	1200 mg	0	3

Dose obese children on lean body weight

**Maximum daily ethambutol dose: See note**

Note: AAP recommends 1 gram as a maximum daily ethambutol dose for children. TB pharmacologists suggest dosing based on lean weight. Max daily dose might exceed 1 gram for a muscular teen.

# TUBERCULOSIS MEDICATION RETURN FORM

## INSTRUCTIONS:

Unused, discontinued, or returned medications (from the client) need to be reviewed and documented before returning to the TB Room every thirty (30) days.

Please provide detailed information in order for the TB Room to properly process the items for return credit or ability to recycle them for future drug orders. Please do not deface packaging prior to return as it may affect its ability to receive credit. Timely returns can help prevent accidental administration to an incorrect client or improper dosing during therapy modifications.

“Leftover or unused medications” can be an area of concern regarding one of the requirements of 340B compliance in preventing drug diversion. [Drug diversion](#) in the program is defined as a 340B drug being provided to an individual who is not an eligible outpatient of that entity and/or dispensed in an area of a larger facility that is not eligible (eg, an inpatient service or a non-covered clinic).

Examples of drug diversion include:

- Dispensing 340B drugs at ineligible sites.
- Not monitoring and correcting inventory.
- Dispensing 340B drugs written by ineligible providers.

**Do not administer or dispense unused medication for another client as it is specifically labeled for an intended person, doing so may be considered an act of diversion and inappropriate practice of care. Violations could affect the State’s drug purchasing contract and your professional license to practice based upon your professional regulations.**

# TUBERCULOSIS MEDICATION RETURN FORM

## TB Form Field Requirements:

Please provide the following information:

- Column A Patient Name
- Column B Select Correct Drug **or** type in drug if not on the dropdown
- Column C Quantity Returning to TB Room (Actual Number of TABS/CAPS)
- Column D Select Appropriate Reason from below (1-7):  
    **1** – Expired    **2** – Overstock    **3** – Change in Therapy/Discontinued    **4** – Lost to Follow Up  
    **5** – Drug Recall    **6** – Client declined therapy    **7** – Other
- Column E If “**7 – Other**” please give brief detail in “Other/Comments”
- Column F Check **YES** **or** **NO** (Field Name “**QUALITY ASSURANCE**”)
  - Please check the appropriate box regarding that Medications have been stored properly at Controlled Room Temperature **and** remained at the Public Health Facility under secure conditions
  - Medications that have left the security of the originating facility and that get returned should be marked a “NO” under the quality assurance check box

---

Name of Facility: Select from dropdown **or** type in facility name

Completed by: Type in your name

Contact Phone #: Enter a contact phone number

Date Sent: Enter in date

---

Return the completed form with medications to:

**ALASKA DHSS / DPH – TB Room**  
**3601 C Street, Suite 586**  
**ANCHORAGE, AK 99503**

Any questions or concerns please contact the Epidemiology TB Room 907-334-0856 or 907-269-8029

### TB MEDICATION RETURN FORM

	A	B	C	D	E	F	F
	Patient Name	Drug Name	Qty	Reason For Return	Other / Comments	Quality Assurance	For Drug Room Use
1						YES <input type="checkbox"/> NO <input type="checkbox"/>	
2						YES <input type="checkbox"/> NO <input type="checkbox"/>	
3						YES <input type="checkbox"/> NO <input type="checkbox"/>	
4						YES <input type="checkbox"/> NO <input type="checkbox"/>	
5						YES <input type="checkbox"/> NO <input type="checkbox"/>	
6						YES <input type="checkbox"/> NO <input type="checkbox"/>	
7						YES <input type="checkbox"/> NO <input type="checkbox"/>	
8						YES <input type="checkbox"/> NO <input type="checkbox"/>	
9						YES <input type="checkbox"/> NO <input type="checkbox"/>	
10						YES <input type="checkbox"/> NO <input type="checkbox"/>	
11						YES <input type="checkbox"/> NO <input type="checkbox"/>	
12						YES <input type="checkbox"/> NO <input type="checkbox"/>	

Name of Facility:

Completed by:

Contact Phone #:

Date Sent:

Return the completed form with medications to:

**ALASKA DHSS / DPH-TB Room  
3601 C Street, Suite 586  
ANCHORAGE, AK 99503**

**Please review items for return every 30 days**

INCLUDE COMPLETED FORM WITH THE ITEMS BEING RETURNED TO THE DRUG ROOM. RETAIN A COPY FOR YOUR RECORDS FOR 2 YEARS.  
ANY QUESTIONS FILLING OUT THIS FORM, PLEASE CONTACT THE DRUG ROOM AT 334-0856 or 269-8029

## **Tuberculosis Screening Questionnaire/Request for Chest X-Ray Interpretation Form Use and Guidelines for Work/School Clearance**

**This form can be used by PHNs to determine if a client with a positive TST or IGRA can be cleared for work or school.** If the client has symptoms of TB (Part 1, #2) or reports risk factors for TB (Part 2, #12-15), refer for further evaluation. This form should be sent to the healthcare provider who will be doing the evaluation and to the AK TB Program.

**If the client has no symptoms or risk factors for TB, they can be cleared for work or school by completing the *Tuberculosis Screening and Clearance* card. The PHN signs the card as the Provider.**

This form should also be submitted with a chest radiograph when recommendations for TB evaluation and/or treatment are being requested from the AK TB Program.



**PART 2:**

8. Have you ever had BCG Vaccine? What Year or Age? \_\_\_\_\_ Yes  No  Don't Know
9. Have you ever been told you have tuberculosis? Yes  No  Don't Know
10. Have you ever taken medications for tuberculosis disease? Yes  No  Don't Know
11. Have you ever taken medications because of a positive skin test? Yes  No  Don't Know

If "Yes," list the name(s) of medication(s): \_\_\_\_\_ Dates: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 \_\_\_\_\_ Dates: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 \_\_\_\_\_ Dates: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 \_\_\_\_\_ Dates: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

12. Was all prescribed medication taken? Yes  No  Don't Know   
 If "No," why not? \_\_\_\_\_

13. Do you have any of the following diseases, conditions, or risk factors?
- a. HIV/AIDS Yes  No  Don't Know   
 If "Yes," Diagnosis Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
- b. Diabetes Yes  No  Don't Know
- c. Lung Disease Yes  No  Don't Know   
 If "Yes," Specify: \_\_\_\_\_
- d. Any disease that affects the immune system; cancer, leukemia? Yes  No  Don't Know
- e. Severe kidney disease Yes  No  Don't Know
- f. Hepatitis Yes  No  Don't Know   
 If "Yes," Specify: \_\_\_\_\_
- g. Use of daily steroids for >1 month Yes  No  Don't Know
- h. Stomach surgery Yes  No  Don't Know
- i. Use of injecting or non-injecting drugs? Yes  No  Don't Know
- j. Foreign born or recent travel to a high burden country Yes  No  Don't Know   
 If "Yes," Country: \_\_\_\_\_ Dates of travel: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
- k. Exposure to a person with active disease? Yes  No  Don't Know

14. Do you drink alcohol? Yes  No  If "Yes," how many alcoholic drinks do you drink? Per day: \_\_\_\_\_ Per week: \_\_\_\_\_
15. Do you smoke? Yes  No  If "Yes," how many cigarettes do you smoke? Per day: \_\_\_\_\_ Per week: \_\_\_\_\_
16. Do you take any prescription medications including steroids, insulin, birth control pills? Yes  No  Don't Know   
 If "Yes," please list medications in the **Comments** below.
17. Do you have any allergies? Please list medications in **Comments** below. Yes  No  Don't Know
18. If female, are you pregnant? Yes  No  Don't Know  If "Yes", when are you due to deliver: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
19. If female, are you post-partum? Yes  No  If "Yes", when did you deliver: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
20. If female, are you breastfeeding? Yes  No  Don't Know

**Comments:**

Primary health care provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Interviewer's name: _____		Date: _____	Phone: _____
Address: _____	City: _____	State: _____	Zip: _____

Submit with the chest x-ray to: **AK Tuberculosis Program**  
 3601 C St, Suite 540  
 Anchorage, AK 99503

**Note: Any x-ray not accompanied by this form will be returned to the submitter.**



**Alaska TB Program  
Section of Epidemiology  
3601 C Street, Suite 540  
Anchorage, AK 99503  
Phone (907) 269-8000, Fax (907) 563-7868**

**Tuberculosis Treatment Contract**

I, \_\_\_\_\_, have been told and counseled by  
\_\_\_\_\_ that I have active tuberculosis (TB).

**The following has been explained to me:**

- TB can be spread through the air to others.
- Without treatment, TB can cause severe illness, disability and death.
- TB treatment usually takes at least 6 months but may take 12 months or longer.
- I must take TB medications for my health and the health of others. This is so important that my TB medications will be provided by directly observed therapy (DOT). This means that a public health nurse (PHN), community health aide/practitioner (CHAP), or DOT aide will be assigned to deliver and watch me take my TB medications.
- I will be considered infectious until the Alaska TB Program gives me clearance. While infectious, I must isolate myself to avoid spreading TB to others.
  - I need to stay at home, without visitors, unless approved by the Alaska TB Program.
  - I will not visit the homes of others, churches, workplaces or other places where I will be in contact with others.
  - If I must go to the store, doctor, or use a taxi, I will wear a mask as instructed.
- I agree to follow-up medical evaluations with my health care provider to make sure that my TB is getting cured and I am not having side effects from my TB medications. This includes keeping appointments, and submitting to blood, sputum and x-ray examinations.
- I agree to notify the PHN, DOT aide/health aide or doctor of any medication side effects that I may have as soon as they occur.
- I agree to assist the PHN and the Alaska TB Program to identify my contacts because they may be at risk for tuberculosis. Contact Investigation is required to prevent and control TB. I understand that I will not be identified by my PHN Case Manager during the contact investigation.
- I have had an opportunity to ask questions and have had my questions answered.

**The Alaska TB Program and my PHN Case Manager will do the following:**

- Provide me with information about tuberculosis, how it is spread, how it is treated and what side effects I might have while taking TB medications.
- Provide all TB medications free of charge.
- Arrange for all TB medications to be given to me by a public health nurse (PHN), community health aide/practitioner (CHAP), or DOT aide.
- Work with me to find the most convenient time and place to provide directly observed therapy during my treatment.
- Arrange for my PHN, CHAP or DOT Aide to monitor and follow-up on any side effects to medications I may experience.
- Work with my health care provider to make sure that I receive and complete approved treatment for my TB.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
PHN Case Manager Signature

\_\_\_\_\_  
Date