



# MINNESOTA LATENT TB INFECTION (LTBI) REPORTING FORM

Return completed form, preferably within **30 days of the completion of the adjustment of status exam**, to the contact listed at the bottom of this form.

Name (last, first, middle)		Sex	
Date of Birth (mm, dd, yyyy)		Country of Birth	
Alien or Visa Registration#:		U.S. Arrival Date (mm, dd, yyyy):	
Address			
City		State	Zip
Daytime telephone number		Mobile telephone number	
Date of First Adjustment of Status (I-693) Exam (mm, dd, yyyy)			
Date Exam Completed (mm, dd, yyyy)			
<b>Clinic Information</b>			
Clinic Name			
Civil Surgeon Last Name		First Name	
Address			
City		State	Zip
Phone		Fax	
Name/title person completing form			
Interpreter needed : <input type="checkbox"/> Yes, language(s) needed: _____ <input type="checkbox"/> No			
<b>Tuberculosis Screening</b>			
Arrival TB Class A or B Status:			
<b>TB screening</b> IGRA Test: (if 2 years and older)	<b>Chest X-Ray – done in U.S.</b> (If IGRA or TST positive, HIV+ or symptomatic)	<b>Diagnosis</b> (must check one) *LTBI Tx candidate	<b>TB Classification</b> (post-exam)
<input type="checkbox"/> QFT <input type="checkbox"/> T-SPOT <input type="checkbox"/> Not Done	<input type="checkbox"/> Done <input type="checkbox"/> Not Done	<input type="checkbox"/> No TB infection or disease	<input type="checkbox"/> No TB Class
IGRA Date: __/__/__	Chest X-Ray Date: __/__/__	<input type="checkbox"/> Latent TB Infection (LTBI)*	<input type="checkbox"/> Class A TB (disease)
IGRA Result: <input type="checkbox"/> Positive	<input type="checkbox"/> Normal	<input type="checkbox"/> Old, healed <u>not</u> prev. Tx TB*	<input type="checkbox"/> Class B2 TB (LTBI)
<input type="checkbox"/> Negative	<input type="checkbox"/> Abnormal, stable, old or healed TB	<input type="checkbox"/> Previously treated LTBI	
<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Abnormal, cavitory	<input type="checkbox"/> Old, healed prev. Tx TB	
<input type="checkbox"/> Borderline	<input type="checkbox"/> Abnormal, non-cavitory, consistent with active TB	<input type="checkbox"/> Active TB disease – (suspected or confirmed)	
<b>Tuberculin Skin Test (TST)</b> (only if younger than 2 years)	<input type="checkbox"/> Abnormal, not consistent with active TB	<input type="checkbox"/> Pending	
<input type="checkbox"/> Not Done			
Date TST Read: __/__/__			
____mm Induration (not redness)	Referral to health department <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Note:** Fill out the Minnesota Latent TB Reporting Form and return to the Minnesota Department of Health Refugee Health Program within 30 days of completion of exam. Inform client of referral. For more information, contact the Refugee Health Program at (651) 201-5414.

**RETURN TO: Refugee Health Program Minnesota Department of Health**

P. O. Box 64925

Saint Paul, MN 55164-0975

FAX: 651-201-5501