DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-000905A (09/2021)

STATE OF WISCONSIN
Wis. Stats § 252.10 (7)
Wisconsin Tuberculosis Program
Telephone: 608-261-6319

TUBERCULOSIS CONTACT WINDOW TREATMENT INITIAL REQUEST FOR MEDICATION

Fields marked with an asterisk (*) are required.
Please complete patient information on pages 1 & 2.

SUBMIT COMPLETED FORM TO:	**Local Health Department (LHD)**	**LHD Fax Number**

*NAME – Patient (Last, First, Middle Initial)				*Date of Birth (mm/dd/yyyy)
*Address (Street or Rural Route)				*Telephone Number
*City		*Zip Code	*LHD/Clinic managing case:	Other contact, as needed
*Sex	*Race	*Ethnicity: ☐ Hispanic ☐ Non-Hispanic		*Weight

***Patient Insurance Information**

☐ Patient has no insurance + financial hardship: WI TB Dispensary covers entire cost.

☐ Patient has insurance (include photocopy of insurance card): WI TB Dispensary to cover co-pay or deductible.
Prescription insurance provider and number:

*NAME – Clinician (Print clearly)	NAME - Hospital/Clinic/Facility
*Address (Street, City, State, Zip Code)	*Telephone Number

Medication	Dose/Frequency		Duration of Therapy
Isoniazid (INH)	**Daily** ☐ **300mg** ☐ mg ☐ Liquid (10-15mg/kg)	**Twice-weekly** ☐ **900mg** ☐ mg ☐ Liquid (20-30mg/kg)	9-months or until negative test 8-10 weeks after last exposure and greater than 6 months of age
Rifampin (RIF)	**Daily/Twice-weekly** ☐ **600mg** ☐ mg ☐ Liquid (15-20mg/kg)		4 months or until negative test 8-10 weeks after last exposure and greater than 6 months of age
Levofloxacin (LFQ)	**Daily Only** ☐ **1000mg** ☐ mg ☐ Liquid (15-20mg/kg)		Contacts to multidrug-resistant TB only. Treatment is 6-12 months and for those greater than 6 months of age

MONITORING ORDERS

1. Assess the patient at least monthly for side effects and medication toxicity. Hold medications and call clinician if present.
2. Directly Observed Therapy (other than relative or guardian) is required for children in Wisconsin

***SIGNATURE** – Clinician:	*Date Prescription Ordered:

To be completed by Local Health Department	
WEDSS Disease Contact/Incident Number	Ship medication to:
Pharmacy: ☐ TB Dispensary Pharmacy ☐ Other, list:	

Patient Name: **Patient WEDSS DI:**

PATIENT INFORMATION - Please note the risk factors for infection, below. Remember when referring a patient for treatment that a patient must have risk factors for infection BEFORE having risk of progression.

A. *Reasons for Treatment

Contact Name: **Contact WEDSS DI:**

Jurisdiction

B. *Is patient symptomatic? (check all that apply) ☐ **No**

☐ Fever ☐ Night sweats ☐ Cough > 3 weeks ☐ Sputum ☐ Blood in sputum ☐ Weight loss

☐ Other:

C. *Initial Test:

1. T-Spot™ blood assay:

   Date Drawn: **Results:** ☐ Positive ☐ Negative ☐ Borderline ☐ Invalid

2. Quantiferon™ (QFT) blood assay:

   Date Drawn: **Results:** ☐ Positive ☐ Negative ☐ Indeterminate

   QFT Numeric results: Nil IU/mL TB1 Nil IU/mL TB2 Nil IU/mL Mitogen IU/mL

3. Tuberculin Skin Test:

   Date Applied: Date Read: Results **(induration only)** mm

4.

Specimen (Sputum/BAL) or Gastric Aspirate	**Date Collected**	**Results**		
		Smear	**PCR**	**Culture**

D. *Follow-up Test or First Test (if after 8-10 weeks from last exposure):

1. T-Spot™ blood assay:

   Date Drawn: **Results:** ☐ Positive ☐ Negative ☐ Borderline ☐ Invalid

2. Quantiferon™ (QFT) blood assay:

   Date Drawn: **Results:** ☐ Positive ☐ Negative ☐ Indeterminate

   QFT Numeric results: Nil IU/mL TB1 Nil IU/mL TB2 Nil IU/mL Mitogen IU/mL

3. Tuberculin Skin Test:

   Date Applied: Date Read: Results **(induration only)** mm

E. *Initial Chest Imaging:

Date: **Results:** ☐ Normal ☐ Abnormal ☐ Cavity

If chest imaging is abnormal and consistent with TB, three sputum samples or gastric aspirate should be submitted to the WSLH for smear, PCR and culture, before treatment for LTBI can begin.

F. *Follow-up Chest Imaging if needed (after two months of window treatment to assess for TB disease)

Date: **Results:** ☐ Normal ☐ Abnormal ☐ Cavity

If chest imaging is abnormal and consistent with TB, three sputum samples or gastric aspirate should be submitted to the WSLH for smear, PCR and culture, before treatment for LTBI can begin.

References

Centers for Disease Control and Prevention. 2017. Official American Thoracic Society/Infectious Diseases Society of America/Centers for Disease Control and Prevention clinical practice guidelines: Diagnosis of tuberculosis in adults and children, *Clinical Infectious Diseases, 64*(2): pp. 29-30. Retrieved from https://www.cdc.gov/tb/publications/guidelines/pdf/ciw778.pdf

Red Book. 2018-2021 Report of the Committee on Infectious Diseases. American Academy of Pediatrics. 31st Edition. 2018. Therapy for Contacts. p.852.

National Society of TB Clinicians and National TB Controllers Association. 2021. Testing and Treatment of Latent Tuberculosis Infection in the United States: Clinical Recommendations. Section 5: Children. pp. 54-57.

Centers for Disease Control and Prevention. 2005. Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis. Recommendations from the National Tuberculosis Controllers Association and CDC. *Morbidity and Mortality Weekly Report* December 16, 2005. Vol.54, No. RR-15.p17.