



**TREATMENT OF LATENT TB INFECTION**  
**NORTH DAKOTA DEPARTMENT OF HEALTH**  
 SFN 50250 (9/01)

**Instructions:** When a client initiates treatment for latent TB infection, complete the shaded area of this form and submit the pink copy, along with the TB Test Registration card, to the address below. Retain the white and yellow copies of the form, and record monthly medications as dispensed. When treatment is complete, or the case is closed, sign and date the form and submit the white copy to the TB Program. Retain the yellow copy for your records. If the client did not complete treatment, please indicate the reason for incomplete treatment in the “comments” area.

This form does not replace the TB Test Registration card. Use a separate form for each client. Press hard when completing this form, and check pink form for legibility. Call 1.800.472.2180 with questions.

Send card and form to: **TB Program**  
**N. D. Department of Health**  
**2635 E. Main Ave., PO Box 5520**  
**Bismarck, N. D. 58506-5520**

<b>Client’s Name (Last, First, Middle)</b>				<b>Date of Birth</b>				
<b>Health Unit/Facility Providing Medication</b>				<b>Phone</b>				
<b>Physician’s Name</b>			<b>Has TB Test Registration card been sent to NDDoH?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>					
<b>Treatment Regimen (check all that apply)</b> INH <input type="checkbox"/> RIF <input type="checkbox"/> PZA <input type="checkbox"/>		<b>Date Treatment Was Started</b>			<b>Length of Treatment Prescribed</b>			

Treatment Month	Date Filled	Person Dispensing Drug	INH	# of Pills Given	B6	# of Pills Given	Alternative Regimens			
							PZA	# of Pills Given	RIF	# of Pills Given
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

**Comments**

Signature

Date Signed