Wyoming Department of Health
Tuberculosis Program
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Latent Tuberculosis Treatment Completion or Discontinuation Letter

Today's date:_____ Patient's date of birth:_____

Patient's last name:_____ First name:_____

Select the latent TB infection treatment regimen prescribed to this patient:

- ☐ 3HP: Isoniazid and Rifapentine, once a week x 3 months, **Directly Observed Therapy**
- ☐ 4R: Rifampin, daily, x 4 months
- ☐ 3HR: Isoniazid and Rifampin, daily x 3 months
- ☐ 6H: Isoniazid x 6 months, daily x 6 months
- ☐ 6H: Isoniazid x 6 month, twice a week x 6 months, **Directly Observed Therapy**
- ☐ 9H: Isoniazid x 9 months, daily x 9 months
- ☐ 9H: Isoniazid x 9 months, twice a week x 9 months, **Directly Observed Therapy**
- ☐ Other CDC-approved LTBI regimen:_____

_____

Treatment start date:_____ Treatment end date:_____

☐ This patient successfully **completed** the above treatment regimen for latent tuberculosis.

☐ Treatment for latent tuberculosis was **discontinued** before completing the regimen.

If treatment was discontinued, please describe the rationale for discontinuation:_____

_____

_____

TB Case Manager Signature:_____ Date:_____