Wyoming Department of Health
Tuberculosis Program
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Cheyenne, WY 82002
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Active Tuberculosis Treatment Completion or Discontinuation Letter

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

Patient's last name:_____ First name:_____

	Medication	Dose	Frequency	Duration
☐	Rifampin (RIF)			
☐	Isoniazid (INH)			
☐	Pyrazinamide (PZA)			
☐	Ethambutol (EMB)			
☐	Moxifloxacin (MOX)			
☐	Other:			
☐	Other:			
☐	Other:			

Treatment start date:_____ Treatment end date:_____

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

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

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

_____

_____

_____

_____

TB Case Manager Signature:_____ Date:_____