

Completion of TB Treatment Letter

To whom it may concern:

This letter is to document that _____ has completed treatment for *(circle one of the following)* Latent TB Infection / Active TB disease.

However, no treatment is perfect and in the event of symptoms compatible with reinfection of TB, such as weakness, tiredness, cough that hangs on, unexplained loss of 10 pounds or more, sweating at night, etc., an x-ray and bacteriological examinations are very important.

Since the patient has had a positive TB test in the past it is not uncommon for those to stay positive for the rest of their life and is of very little importance for the diagnosis of TB for the future. Serial or repeat chest x-rays are not indicated unless they develop symptoms suggestive of active TB disease. For future work requirements, a risk assessment should be done and from that you can determine the need for a chest x-ray or further assessment by a medical professional.

The following information is intended for the patients' medical record:

Type of TB test done: _____ **Result of that test:** _____

Results of chest x-ray results: _____

Medication regimen the patient was on: *(list all medications, doses and frequencies separately)*

Medication	Dose	Duration

For treatment records please contact _____ County Health Department.

Signature of Health Department Nurse

___/___/___

Date

County of Patient's Residence