Tuberculosis Screening/Testing Form

Name: _____ **Date of Birth:** ____/____/

THIS FORM IS TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER

Based on the guidelines published from the Centers for Disease Control (CDC) Tuberculosis Screening is required annually for health care workers, including all medical students. For more information, refer to the CDC's Core Curriculum on Tuberculosis available at website: www.cdc.gov/nchstp/tb/pubs/corecurr/.

All students must complete either section **A** or **B** below. Please refer to the Immunization Policy for detailed instructions and explanation. **Attach results/Lab reports appropriate to method selected.**

A. 2-Step Tuberculin Skin Test

Test 1:

Date given: ____/____/____(Mo/Day/Yr) Date read: ____/____/____(Mo/Day/Yr)

Result: _____mm ☐**Positive** ☐ **Negative** (Record actual mm of induration, transverse diameter; if no induration, write "0")

***Tests must have at least 7 days but not more than 3 weeks between 1st reading and 2nd placement or the series must be repeated**

Test 2: (Must be administered at least 7 days after 1st Reading)

Date given: ____/____/____(Mo/Day/Yr) Date read: ____/____/____(Mo/Day/Yr)

Result: _____mm ☐**Positive** ☐ **Negative** (Record actual mm of induration, transverse diameter; if no induration, write "0")

OR

B. Immunoassay Blood Test

Date performed: ____/____/____ Results: ☐Positive ☐Negative

***If TB test is POSITIVE, please proceed to sections C and D below.**

C. Chest X-Ray (required ONLY if Tuberculin Skin test or Immunoassay Blood Test is POSITIVE; or if history of positive PPD and/or patient is at risk of active disease.

Result: ☐Normal ☐ Abnormal Date of last chest x-ray: _____/____/____

D. Previously Treated LTBI – students previously treated for LTBI must complete the following:

Dates (i.e. length) and details (i.e. drugs, dose) of LTBI treatment regimen: ____/____/____to ____/____/____

HEALTH CARE PROVIDER or NURSE:

Name: _____ Signature: _____

Address: _____

Phone: _____

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