

## TUBERCULOSIS TESTING

|           |            |        |            |
|-----------|------------|--------|------------|
| LAST NAME | FIRST NAME | MIDDLE | BIRTH DATE |
|-----------|------------|--------|------------|

**All schools in the College of Health Sciences require tuberculosis (TB) screening prior to enrollment in courses, requirements vary by school and/or program. Please refer to your school/program's student handbook for specific requirements regarding tuberculosis (TB) screening requirements. Only this form will be accepted to meet program/school requirements. If you have received a BCG vaccine, an IGRA test is preferred. If you have a history of a positive TB skin test ( $\geq 10\text{mm}$ ) or IGRA, please supply information regarding any evaluation and/or treatment below. Guidelines are based upon the recommendation of the CDC and the American College Health Association.**

\*\*\*Skin tests **MUST** be read 48-72 hours after they are placed.

\*\*\*The second test in a two-step TB test **MUST** be administered between one (1) and three (3) weeks after the first test was read.

| Section A                                                                       | Test Type                                                                                       | Date Placed/Ordered | Date Read/Resulted | Results                        |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------|--------------------|--------------------------------|
| No history of positive TB tests.<br><br>Skin Test <b>OR</b> Blood Test Required | Skin Test #1                                                                                    | ____/____/____      | ____/____/____     | ____ mm                        |
|                                                                                 | Skin Test #2                                                                                    | ____/____/____      | ____/____/____     | ____ mm                        |
|                                                                                 | IGRA Blood Test<br><input type="checkbox"/> T-spot<br><input type="checkbox"/> Quantiferon Gold | ____/____/____      | ____/____/____     | ____ Negative<br>____ Positive |
|                                                                                 | Chest X-ray                                                                                     | ____/____/____      | ____/____/____     | ____ Negative<br>____ Positive |

**OR**

| Section B                                                                                              | Positive Test Type                                                                                       | Date Placed/Ordered                                      | Date Read/Resulted                   | Results                        |
|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------|--------------------------------|
| History of Latent Tuberculosis, Positive Skin Test, or Positive Blood Test<br><br>Chest X-Ray Required | Positive Skin Test                                                                                       | ____/____/____                                           | ____/____/____                       | ____ mm                        |
|                                                                                                        | Positive IGRA Blood Test<br><input type="checkbox"/> T-spot<br><input type="checkbox"/> Quantiferon Gold | ____/____/____                                           | ____/____/____                       |                                |
|                                                                                                        | Chest X-ray                                                                                              | ____/____/____                                           | ____/____/____                       | ____ Negative<br>____ Positive |
|                                                                                                        | Prophylactic medications for latent TB taken?                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                      |                                |
|                                                                                                        | Total duration of prophylaxis?                                                                           | ____ months                                              |                                      |                                |
|                                                                                                        | Date of last annual TB symptom questionnaire (if applicable)                                             | ____/____/____                                           | <input type="checkbox"/> Attach copy |                                |

**OR**

| Section C                                                           | Date                                                         | Results                                                                                  |
|---------------------------------------------------------------------|--------------------------------------------------------------|------------------------------------------------------------------------------------------|
| History of Active Tuberculosis<br><br>History of Treatment Required | Date of Diagnosis                                            | ____/____/____<br><input type="checkbox"/> Attach copy                                   |
|                                                                     | Date Treatment Completed                                     | ____/____/____<br><input type="checkbox"/> Attach copy                                   |
|                                                                     | Date of last annual TB symptom questionnaire (if applicable) | ____/____/____<br><input type="checkbox"/> Attach copy                                   |
|                                                                     | Date of last Chest X-ray                                     | ____/____/____<br>____ Negative<br>____ Positive<br><input type="checkbox"/> Attach copy |

**This form must be completed by one of the following licensed healthcare providers: MD, DO, NP/CRNP, PA, RN, or LPN. The form must be dated NO EARLIER THAN the last listed test date on the form to be valid. Nothing should be added to form after the healthcare provider signs and dates UNLESS the individual addition is signed, credentialed, and dated.**

Licensed Healthcare Provider's Printed Name and Credentials: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SIGNATURE OF PROVIDER: \_\_\_\_\_ DATE: \_\_\_\_\_