Walk a Different Path

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Tuberculosis (TB) Screening Form (Cont.)

Student to complete this section BEFORE taking to health care provider.

Student Name: ____________________________Date of Birth:____________Today's Date:____________
(PRINT)

I have completed the tuberculosis pre-screening form and checked YES to one or more questions. **Because I checked yes on one or more of these questions, I am required to get a PPD** (or if my health care provider deems a blood test is necessary, a T-spot or IGRA). **Check off the questions you checked YES to on the online pre-screening:**

- Have you recently had close contact with someone with infectious tuberculosis
- Have you had changes on a prior chest x-ray suggesting inactive or latent, or prior tuberculosis infection?
- Are you positive for HIV?
- Are you an organ transplant recipient?
- Are you immunocompromised due to an illness or medications that you take on a regular basis?
- Do you have a history of using illegal injectable drugs?
- Are you (or have you been within the last year) a resident, employee, or volunteer in a high-risk setting (e.g. correctional
  - facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)?
- Were you born in a country with a high incidence of TB (other than North America or West Europe)?
  - If yes, which country? ____
- Have you had frequent or prolonged visits (longer than 6 months) to one or more of the countries with a high incidenceof TB in the past 2 years ?
  - If yes, which country? ____

I have completed the Cairn University tuberculosis pre-screening form and checked YES on questions 10 and/or 11. **Because I checked yes on one of these questions, I am required to get a TB blood test – either a T spot or IGRA. A PPD skin test will NOT be accepted** under any circumstances and a failure to have this blood test done may cause delays. **Check off the questions you checked YES to on the online pre-screening:**

- Have you ever been vaccinated with BCG?
- Have you ever had a positive TB test in the past?

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THIS SECTION IS TO BE COMPLETED BY HEALTH CARE PROVIDER:

Tuberculin Skin Test: Date placed: ____________________Date read: __________________ Results:_______________mm

Lot # ____Expiration date: ____

Signature (administered by): ____ **IF PPD is greater than 10 mm, proceed to IGRA or Tspot**

Quanti-FERON Test Results: Positive ( ) Negative ( ) T-spot Results: Positive ( ) Negative ( ) Borderline or Indeterminate results must be repeated

Chest x-ray (required if IGRA or Tspot test is positive): Date: ______________ Normal ( ) Abnormal ( )

**MUST ATTACH COPYS of all LABS AND XRAYS **

INH Treatment: Initiate Date ________________________________ X ______________________ months. Declined ( )

Health Care Provider signature____ Date: _______________________
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