ANNUAL PAST-POSITIVE TB SCREENING QUESTIONNAIRE F19-S20 AY

Student’s Name ___________________________ Student’s Date of Birth __________________________

Tuberculosis (TB) Screening Questions:

1. Have you ever had a positive TB skin test? ☐ Yes ☐ No
2. Have you been vaccinated with BCG? ☐ Yes ☐ No
3. Are you allergic to the TB skin test (PPD)? ☐ Yes ☐ No

If the answer to all of the above questions is NO, there is no need to complete this form. Proceed with yearly TB skin test screenings.

If one of the answers above is YES, have your health care provider complete the tuberculosis risk assessment below.

TB Risk Assessment

1. Does the patient have signs or symptoms of active TB? ☐ Yes ☐ No (Response Required)
   If no, then proceed to #2. If YES, then proceed with further evaluation as indicated.

2. Medical assessment
   a. Has +PPD been noted previously? ☐ Yes ☐ No
      ➢ If yes, then chest x-ray is required May 1, 2019 or later for students admitted Fall 2019 & Spring 2020:
         Date of CXR ___/___/____ & Result: ☐ Normal ☐ Abnormal
      ➢ If yes, has the patient completed a 9 mo course of INH? ☐ Yes, completed ___/___/___ ☐ No
  
   b. If no past history of + PPD or IGRA, then PPD or IGRA must be done regardless of BCG status.
      The PPD should be recorded as actual millimeters of induration and interpreted based on the guidelines (** below).
      Date Placed: ___/___/____ Date Read: ___/___/____ Result: ______mm of induration
      **Interpretation (see guidelines below): ☐ Positive ☐ Negative

   c. Interferon Gamma Release Assay (IGRA)
      Date obtained: ___/___/____
      Method: ☐ QFT-G ☐ QFT-GIT ☐ Other_______
      Result: ☐ Positive ☐ Negative ☐ Intermediate
      If the IGRA is POSITIVE, then chest x-ray is required May 1, 2019 or later for students admitted Fall 2019 & Spring 2020:
      Date of CXR ___/___/____ & Result: ☐ Normal ☐ Abnormal

**Interpretation Guidelines
> 5 mm is positive: Recent close contact with person with active TB/ Abnormal CXR c/w past TB disease/
Organ transplant or other immunosuppression/ HIV/AIDS
>10 mm is positive: Significant travel or residence in high prevalence area/ Illicit drug use / Worker in healthcare, homeless shelter, prisons/
Chronic health issues
>15 mm is positive if no risk factors

HEALTH CARE PROVIDER SIGNATURE (Required):
Printed Name_________________________ Phone: __________________ Fax: ___________________
Address__________________________________________

Signature__________________________________________ (Required) Date_______________________

Revised 3/12/2019