# TB SCREENING FORM

## TELL US THE REASON(S) FOR YOUR TB SCREENING TODAY (CHECK ALL THAT APPLY)

- [ ] I need a TB test for work or school. (employer or school): ______________________
- [ ] Other reason: ______________________________________________________________

## PLEASE ANSWER THE FOLLOWING QUESTIONS:

### Were you born or raised outside the USA?

**Yes** ☐ **No** ☐  
- Country of Birth: __________________________
- Year entered the USA: __________
- Received BCG* vaccine?  **Yes** ☐  **No** ☐  
- Year of last BCG: ___________________  **N/A** ☐

*B CG = a TB vaccine given in some countries (but not in the USA)

### Ever had a Positive** TB test?

**Yes** ☐ **No** ☐  
- Year of Positive TB test: __________
- Type of test: _________________________  **Skin test** ☐  **Blood (Quantiferon)** ☐

**Positive TB Skin Test = Raised bump at test site; told by health care professional it was TB positive, usually requires a Chest X-Ray**

### Ever had a Chest X-Ray for TB?

**Yes** ☐ **No** ☐  
- Year of Chest X-Ray: __________
- Result:  **Active TB** ☐  **Not Active TB** ☐

### Ever taken INH (Isoniazid) for TB?

**Yes** ☐ **No** ☐  
- Year you took INH: __________
- Number of months taken: __________

### Do you have these symptoms?

- [ ] Yes ☐ No  Cough lasting more than 3 weeks?  
- [ ] Yes ☐ No  Coughing up blood?  
- [ ] Yes ☐ No  Unintentional weight loss?  
- [ ] Yes ☐ No  Loss of appetite?  
- [ ] Yes ☐ No  Fever?  
- [ ] Yes ☐ No  Sweating at night?  
- [ ] Yes ☐ No  Allergic to medications or vaccines?  
- [ ] Yes ☐ No  Had contact with, or lived with someone sick with active TB?  
- [ ] Yes ☐ No  Lived or worked in a refugee camp, homeless shelter or jail?  
- [ ] Yes ☐ No  Been a health care worker?  
- [ ] Yes ☐ No  Traveled to the developing world and had close contact with the local population?  

I certify that the information I have provided is true to the best of my knowledge. I will not hold this clinic or its staff responsible for any errors or omissions I may have made in completing this form.

Client Signature _______________  Date _______________

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### AITC STAFF USE ONLY

<table>
<thead>
<tr>
<th>TEST</th>
<th>1-Step TST</th>
<th>2-Step TST</th>
<th>QFT-IT Gold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step</td>
<td>Date Placed</td>
<td>Site</td>
<td>Lot #</td>
</tr>
<tr>
<td>#1</td>
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<td>#2</td>
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**ASSESSMENT:**  
- [ ] Pos  **Neg**  State TB Risk Assessment  
- [ ] Yes  **No**  AITC TB Risk Factor(s)  
- [ ] Yes  **No**  AITC TB Symptoms  
- [ ] Pos  **Neg**  **Ind** TST Step #1  
- [ ] Pos  **Neg**  TST Step #2  
- [ ] Pos  **Neg**  **Ind** QFT-IT Gold

**PLAN:**  
- [ ] State Certificate Completed  
- [ ] Yellow Card w/Result  
- [ ] TB-47 Given

- [ ] Symptom Review Only (skip to p. 2)

Clinician Signature: ___________________________ Date: ___________________________
### TB SCREENING FORM - continued

**History of LTBI**

<table>
<thead>
<tr>
<th><strong>AITC STAFF USE ONLY</strong></th>
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<tbody>
<tr>
<td><strong>TB Testing</strong></td>
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<tr>
<td><strong>CXR</strong></td>
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**Sx Review**

- [ ] Positive for Sx
- [ ] Negative for Sx

**LTBI Tx**

- [ ] Treated: Completion Documented
  - [ ] (Attach Copy of Documentation)
- [ ] Incomplete: Not completed, Not Documented, or Documentation Unavailable
- [ ] Not Treated

**Congregate**

- [ ] Yes
- [ ] No

Employee or resident of Congregate Living setting (jail, shelter, SNF, rehab, etc)

**Exposure**

- [ ] Yes
- [ ] No

Recent (since last TB eval) exposure to Active TB Case

**Risk Factors**

- [ ] Yes
- [ ] No

- HIV or other significant immune compromise due to illness or medication
- TB test conversion within past 2 years
- On immune modulator therapy for autoimmune disease
- End Stage Renal Disease, silicosis, jejuno-ileal bypass, or head/neck carcinoma
- Old inactive TB on prior CXR
- Diabetes, gastrectomy, IV drug use, or malnutrition

**DISPOSITION / PLAN**

- [ ] (A) No F/U needed unless new TB exposure or Sx develop
- [ ] (B) Return annually for Sx Review — get CXR whenever symptomatic
- [ ] (C) CXR / PCP Visit now to evaluate for TB reactivation. (If NEG, return for annual Sx review.)
- [ ] (D) CXR now to evaluate for TB reactivation; Plus Sx Review every 3 mos, CXR every 6 mos
- [ ] (E) CXR now to evaluate for TB reactivation; Plus CXR & Sx Review every 6 mos x 2 years
- [ ] (F) CXR now to evaluate for TB reactivation; Plus Sx Review every 6 mos, CXR annually
- [ ] (G) CXR now to evaluate for TB reactivation; Plus CXR & Sx Review annually

Referral To: ________________________________

Clinician Signature: ___________________________ Date: ________________