IMMUNIZATION & TRAVEL CLINIC
SF DEPARTMENT OF PUBLIC HEALTH

TB SCREENING FORM

NAME:_____ **BIRTHDATE:**_____

⇨ 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:

☐Yes ☐No **Were you born or raised outside the USA?**

If Yes ⇨
Country of Birth _____
Year entered the USA _____
Received BCG* vaccine? ☐Yes ☐No
Year of last BCG _____ ☐N/A

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

_____ **Date of Most Recent TB Test**
day / mo / yr
Type of test ☐Skin test ☐Blood (Quantiferon)
☐Never had
☐Don't know

☐Yes ☐No **Ever had a Positive** TB test?**

If Yes ⇨
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.*

☐Yes ☐No **Ever had a Chest X-Ray for TB?**

If Yes ⇨
Year of Chest X-Ray _____
Result ☐Active TB ☐Not Active TB

☐Yes ☐No **Ever taken INH (Isoniazid) for TB?**

If Yes ⇨
Year you took INH _____
Number of months taken _____

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*** _____

☐Yes ☐No Take any medications?
If yes, list:

☐Yes ☐No Have any medical conditions?
If yes, list:

☐Yes ☐No Have a condition or take a medicine that weakens the immune system?
☐Yes ☐No Currently pregnant?
☐Yes ☐No Faint or get lightheaded with needles?
☐Yes ☐No Allergic to medications or vaccines?
If yes, list:

Have you ever:
☐Yes ☐No Been sick with, or treated for TB?
☐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? *If yes, describe:*

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?

⇨ AITC STAFF USE ONLY

TEST: ☐ 1-Step TST ☐ 2-Step TST ☐ QFT-IT Gold ☐ Symptom Review Only (skip to p. 2) →

Step	Date Placed	Site	Lot #	Placed By	Date Read	Result	Read By
#1	_____	R L	_____	_____	_____	____ mm	_____
#2	_____	R L	_____	_____	_____	____ mm	_____

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
☐ CXR Referral Form ☐ Education per Protocol
☐ Other Referral To: _____ For: _____

Clinician Signature: _____ Date: _____

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TB SCREENING FORM - continued

History of LTBI

⇨ AITC STAFF USE ONLY

TB Testing (list dates, test types, findings) _____

_____

CXR (list dates, findings, esp. most recent CXR) _____

_____

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
	☐ Yes ☐ No	TB test conversion within past 2 years
	☐ Yes ☐ No	On immune modulator therapy for autoimmune disease
	☐ Yes ☐ No	End Stage Renal Disease, silicosis, jejuno-ileal bypass, or head/neck carcinoma
	☐ Yes ☐ No	Old inactive TB on prior CXR
	☐ Yes ☐ No	Diabetes, gastrectomy, IV drug use, or malnutrition

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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: _____