**Tuberculosis (TB) Screening Form**

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| **Name:** |  | **Date of Birth:** |  |

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| **Please answer the following questions:** |
| **Section 1** | **Have you ever had a positive TB test?**Year of test: \_\_\_\_\_\_\_\_\_\_\_\_ Type of test: [ ]  Skin test [ ]  Blood test | [ ]  Yes [ ]  No |
| **Have you ever taken medications for TB infection?**Year taken: \_\_\_\_\_\_\_\_\_\_\_\_\_List medications taken:  | [ ]  Yes [ ]  No |
| **Have you received any vaccines within the last 28 days?** List vaccines: | [ ]  Yes [ ]  No |
| **Section 2** | **Have you ever received the BCG\* vaccine?***\*BCG is a TB vaccine given in some countries outside of the United States. A TB blood test with your primary care provider is recommended for individuals who have received BCG vaccine.*  | [ ]  Yes [ ]  No |
| **Have you spent at least 1 month in a country with elevated risk\* for TB, this includes birth, travel, or residence?***\*Countries with increased risk include any country except the United States, Canada, Australia, New Zealand, or a country in western or northern Europe.*If yes, what country?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What year did you leave that country?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No |
| **Do you have any of the following symptoms?** | [ ]  Yes [ ]  No |
| [ ]  Cough lasting longer than 2 weeks[ ]  Unexplained weight loss or loss of appetite[ ]  Night sweats | [ ]  Coughing up blood[ ]  Fever or chills[ ]  Excessive fatigue |
| **Section 3** | **Have you tested positive for HIV infection or are you at risk for HIV infection?** | [ ]  Yes [ ]  No |
| **Do you have a suppressed immune system caused by a condition or take a medicine that weakens the immune system, such as any of the following?**[ ]  Taking medications that suppress the immune system such as TNF-alpha antagonist medications (e.g., infliximab, etanercept, others) or steroids[ ]  Organ or tissue transplant; cancer of the head, neck or lung; leukemia; or lymphoma | [ ]  Yes [ ]  No |
| **Have you ever been a close contact to someone with infectious TB disease?**If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_ (month/year) Did this person live in the same house with you? [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| **Have you had an abnormal chest X ray before that suggested TB disease?** If yes, when?: \_\_\_\_\_\_\_\_\_\_ (month/year) Do you have a copy of the results? [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |

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| **CLINIC USE ONLY** |
| **Review screening form on day of TST placement.**  | **Registration form:** | Patient has insurance: Patient has a primary care provider: Child is **under 5 years** of age: | [ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No |
| **Section 1:**  | [ ]  *NO’s* only. Okay to proceed with TST placement today.[ ]  *YES* and/or live vaccine within 28 days. Do not place TST today. |
| **Section 2:**  | [ ]  No history of BCG vaccine.[ ]  Yes, patient received BCG vaccine. Education provided to patient that blood test is preferred as BCG may cause false positive TST. |
| **Section 3:**  | [ ]  *No*’s only. TST will be interpreted as positive if 10mm or greater. [ ]  *Yes*’s present. TST will be interpreted as positive if 5mm or greater. |
| Reviewer’s signature:  | Date:  |
| **If TST is positive, complete this section.** | **Measuring of TST:** Date placed: \_\_\_\_\_\_\_ Date read: \_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_mm Measured by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Interpretation of TST:** [ ]  Positive [ ]  Negative Result interpreted by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ |
| 1. Determine if TB Clinic referral needed.
 | **Does patient meet criteria to be referred to TB Clinic?** *(Patients under 5 years of age who are born in US (ie, no prior BCG) must be referred to TB Clinic--send CMR to TB Clinic and call TB staff nurse).* |
|  | [ ]  Yes. CMR sent to TB Clinic and TB Staff Nurse notified.[ ]  No. IZ Clinic will proceed with steps 2-6 noted below. |
| 1. CXR Order signed by MD and provided to family.
 | [ ]  **CXR order is delayed:** 1. Family is advised to return for the CXR order on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_ (date).
2. CXR order form and TB screening form placed in TB Program area for MD review & signature.
3. Signed CXR order and imaging referral list placed at IZ reception prior to family’s scheduled return date (noted in #1).
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| [ ]  **Signed CXR order and imaging referral list given to family** on: \_\_\_\_\_\_\_\_(date).* Appointment to review CXR results: \_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_­­\_\_\_\_\_ (date/time).
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| 1. CXR results signed by MD.
 | [ ]  **CXR results received from imaging facility and placed in TB Program**, with TB Screening form attached, for MD signature. |
| [ ]  **Signed CXR returned to IZ Clinic** and ready for scheduled appointment. |
| 1. School clearance determined.
 | **Does patient meet criteria for school clearance?** *(Patient must have a clear CXR and NO symptoms suggestive of active TB disease to receive school clearance.)* |
|  | [ ]  Yes, patient meets criteria to receive clearance.[ ]  No. Clearance not given, nurse to discuss next steps with FCDPH provider. |
| 1. Documents provided to patient.
 | [ ]  **Copies of documents provided to patient** on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date). |
| * Signed CXR
* Referral to PCP form
 | * Provider referral list
* School clearance (if applicable)
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| [ ]  **Patient has not returned for documents** despite contact attempts.  |
| 1. Save record.
 | [ ]  **Documents saved** per IZ practices. |