**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). | | | | |
| **Signed CXR order and imaging referral list given to family** on: \_\_\_\_\_\_\_\_(date).   * Appointment to review CXR results: \_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_­­\_\_\_\_\_ (date/time). | | | | |
| 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) | | |
| **Patient has not returned for documents** despite contact attempts. | | | | |
| 1. Save record. | | **Documents saved** per IZ practices. | | | | |