TUBERCULOSIS (TB) SCREENING FORM TODAY'S DATE: _____/_____/_____

A. SELF-ASSESSMENT (TO BE COMPLETED BY PATIENT OR PARENT / GUARDIAN)

Name: Last:_____ First:_____ Middle:_____Date of Birth: ___/___/___

Address: _____
Street Apt. # City State Zip Code

Phone: ( )_____( )_____ ( )_____
Home Cellular Emergency Number

1. Have you ever had a TB skin test? ☐Yes ☐No ☐Don't know
   - If yes, when was it? ____/____/____ •What was the result? ☐Positive ☐Negative ☐Don't know
   - If positive, do you have the documentation? ☐Yes ☐No
2. Did you have a chest x-ray after your skin test? ☐Yes ☐No
   - If yes, when? ____/____/____
   - Where was it? (e.g., name of hospital, doctor, clinic)_____
3. Have you ever been told that you have TB? If so, when: ____/____/____
4. Have you ever been treated for TB infection or TB disease? ☐Yes ☐No
   - Which medicines did you take? _____
   - How long were you on the treatment? _____

Please place a √ mark in one of the columns to the right	**Yes**	**No**	**Don't Know**
5. Have you ever been told, or suspected, that you were exposed to someone with TB? •If yes, when: ____/____/____ Name /Relationship:_____			
6. Have you ever had cancer of the head, neck or lung; leukemia; or lymphoma?			
7. Have you ever had an organ or tissue transplant?			
8. Are you taking steroids (like prednisone), chemotherapy or drugs that affect your immune system?			
9. Do you have diabetes or high blood sugar?			
10. Do you have any of the following symptoms:			
• Cough longer than 2 weeks? If yes, date you first noticed ____/____/____			
• Fever, chills, night sweats longer than 2 weeks? If yes, date you first noticed ____/____/____			
• Weight loss that was not planned? If yes, date you first noticed ____/____/____			
11. Do you have renal failure, or are you on kidney dialysis?			
12. Do you think you are at risk of having HIV infection?			
13. Have you ever injected street drugs?			
14. Were you born outside of the United States? If yes, what country? _____			
15. (If patient under 18) Has anyone who lives with you moved to the U.S. within the last 5 years? If so, from which country? _____			
16. Have you had any visitors from outside the U.S.? When? _____ Where were they from? _____			
17. Have you traveled to any other countries recently? Where? _____ How long did you stay? _____			
18. Have you ever lived or worked in a group setting such as a hospital, nursing home, drug treatment center, homeless shelter, jail, or prison?			

If you answered "Yes" to any of the questions from 5 to 18, you may be at increased risk of having TB infection of developing active TB. If you answered "No" to all, you are not considered at higher risk for TB.

_____
Patient or Parent/Guardian Signature

FACILITY STAMP

TUBERCULOSIS (TB) SCREENING FORM TODAY'S DATE: _____/_____/_____

PATIENT'S NAME:_____ D.O.B.: ___/____/____
Last First Middle

B. ASSESSMENT OUTCOME AND TB TEST ADMINISTRATION (TO BE COMPLETED BY CLINICIAN)

☐**Prior Documentation (or convincing history) of TB or LTBI:**
No TB test needed. *Patient may still need evaluation for treatment for LTBI or active TB.*

TB Risk Category (check one box only):

☐**Medical risk factor (includes contacts to active TB cases)** (questions 5-12)

☐**Population risk factor** (questions 13-18)

☐**Administrative** (TB test required only for work, school, etc.)

Screening Test: ☐**TST (PPD) Mantoux** (0.1ml of tuberculin) ☐**Blood Test** (QuantiFERON TB Gold)

Test Date: ___/___/___

Tuberculin lot number:_____ **Expiration date**:___/___/___
Date interpreted ___/___/___ Result: _____mm ☐Positive ☐Negative

Blood test IFN-γ concentration: _____IU/mL
Result: ☐Positive ☐Negative ☐Indeterminate

Two Step Testing for Health Care Workers (applicable only if initial TST was negative):
☐2nd TST Mantoux date: ___/____/____
Tuberculin lot number: _____ **Expiration date**:___/___/___
Date interpreted ___/___/___ 2nd result: _____mm ☐Positive ☐Negative

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PHYSICAL EXAM: Date: ___/___/___ ☐*No signs of TB* ☐*Abnormal, Suggesting TB*
CHEST X-RAY: Date: ___/___/___ Reading: _____

OUTCOME (check one box only):

☐LTBI treatment prescribed
☐No treatment needed (Not infected)
☐No treatment indicated (Low TB risk)
☐Treatment deferred due to _____
☐Patient being evaluated as a TB suspect
☐Patient refused treatment
☐Treatment not advised due to high risk of hepatitis
☐Previously treated for TB or LTBI
☐Other_____

Follow-up/Comments (include treatment regimen):

_____

_____

_____

_____

_____ _____ _____
Name (Please Print) Signature Date

NYC Health