ANNUAL PAST-POSITIVE TB SCREENING QUESTIONNAIRE

Student’s Name_________________________ Student’s Date of Birth __________________________

Tuberculosis (TB) Screening Questions:

1. Have you ever had a positive TB skin test?   Yes   No
2. Have you been vaccinated with BCG? (PPD)?   Yes   No
3. Are you allergic to the TB skin test?  Yes   No

If the answer to all of the above questions is NO, there is no need to complete this form. Proceed with yearly TB skin test screenings.

If **ONE** of the answers above is YES, have your health care provider complete the tuberculosis risk assessment below.

**TB Risk Assessment**

1. **Does the patient have signs or symptoms of active TB?** (Response Required)   Yes   No ****If no, then proceed to #2.
   If YES, then proceed with further evaluation as indicated.

2. **Medical assessment**
   a. **Has +PPD been noted previously?**   Yes   No
      If yes, then chest x-ray is required within 12 months of entry:
      Date of CXR ___/___/_____  Result:  Normal   Abnormal
      If yes, has the patient completed a 9 mo course of INH?  Yes   No
   b. If no past history of + PPD or IGRA, then PPD or IGRA must be done regardless of BCG status. **The PPD should be recorded as actual millimeters of induration and interpreted based on the guidelines (**) below.**
      Date Placed: ____/____/_____  Date Read: ____/____/____  Result: _____mm of induration
      **Interpretation (see guidelines below):**  Positive   Negative
   c. **Interferon Gamma Release Assay (IGRA)**
      Date obtained: ____/____/____
      Method:  QFT-G  QFT-GIT  Other_______
      Result:  Positive  Negative  Intermediate

**Interpretation Guidelines**

> 5 mm is positive: Recent close contact with person with active TB/ Abnormal CXR c/w past TB disease/Organ transplant or other immunosuppression/ HIV/AIDS

>10 mm is positive: Significant travel or residence in high prevalence area/ Illicit drug use/ Worker in healthcare, homeless shelter, prisons/Chronic health issues

>15 mm is positive if no risk factors

**HEALTH CARE PROVIDER SIGNATURE (Required):**

Printed Name____________________________Phone: ___________________ Fax: _______________
Address_________________________________City/State/Zip_________________________________
Signature_____________________________________________ (Required) Date__________________