Tuberculosis Screening Questionnaire

Student Name: _____ DOB: _____

Do you have a history of a positive TB (Tuberculosis) test? □Yes □ No
Do you have a history of TB disease? □Yes □ No

Please check Yes or No for each of the following risk factors:

Risk Factors

Do you have one or more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue)? □Yes □ No

Have you ever had close contact with a person(s) known to have active TB disease? □Yes □ No

Were you born in any country other than the U.S., Canada, Australia, New Zealand, or a country in Western or Northern Europe? □Yes □ No

Have you recently travelled to a high TB-prevalent country for more than 1 month (any country other than the U.S., Canada, Australia, New Zealand, or a country in Western or Norther Europe? □Yes □ No

Are you a current or former resident, volunteer, healthcare worker, and/or employee of a correctional facility, long-term care facility, hospital, or homeless shelter? □Yes □ No

Have you ever been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? □Yes □ No

Have you ever been a member of any of the following groups that that may have an increased incidence of latent *M. Tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs and alcohol? □Yes □ No

Are you currently immunosuppressed (have HIV infection, organ transplant recipient, history of cancer)? Or have you used Prednisone for $\geq$ 1 month or currently taking other immunosuppressive or chemotherapy medications? □Yes □ No

Do you have a history of an abnormal chest x-ray? □Yes □ No

If you answered No to <u>all</u> of the above questions, no further testing or further action is required. Please sign and date below to complete this requirement.

Signature: _____ **Date:** _____

If you answered YES to <u>any</u> of the above questions, DUC Student Health Center requires that you complete the back of this form with a healthcare professional in order to complete this requirement.

****Please note regardless of whether you responded No to all questions, or answered Yes to any questions and continue to the back of the form, you must return this form to the Student Health Center to meet the Tuberculosis requirement.****

Tuberculosis Screening Questionnaire

This page must be completed by a Healthcare Professional and **proof of testing must be attached** to meet the requirement.

Clinicians should review and verify the information on the previous page. Persons answering **YES** to any of the questions are candidates for either: Mantoux tuberculin skin test (TST) or a Quantiferon Gold Test, unless a previous positive test has been documented which will then require a chest x-ray. Persons with a history of BCG vaccination should have a QGT/IGRA for clearance.

Tuberculosis Testing: TST (Tuberculin skin test) within 1 year of the first day of classes meets the requirement

Date placed: _____/_____/_____ Date read _____/_____/_____ Results: _____ Induration: _____mm

Or Quantiferon Gold/IGRA Blood Test:

Date of blood test: _____ Result: ☐ Positive ☐ Negative
Please attach lab report.

Or chest x-ray for a history of a positive blood test - Must be within 1 year of the first day of classes, with the report attached:

Chest x-ray date: _____ Result: _____

Has the patient received treatment for positive TB test? * **□Yes □ No**

Date treatment began: _____ Date treatment completed: _____

*Please complete the table below indicating the medications, dosages, and duration of treatment.

Medication Name:	Dose:	Duration of Treatment:

Clinician Name (Printed): _____

Clinician Signature: _____ Date: _____

Address: _____

_____

Phone: _____