2014-2015 MANDATORY TUBERCULOSIS SCREENING FORM

Name (please print): ___________________________  UB Person #: ___________________________

Last    First    MI

Country of Birth: ___________________________  Year arrived in US: ___________________________

SECTION A: History of Tuberculosis (TB)?

1. Have you ever been sick with tuberculosis?  YES ☐ NO ☐
2. Have you ever had a positive PPD, TB Quantiferon test, or T-SPOT?  YES ☐ NO ☐

SECTION B: At Risk for Tuberculosis (TB)?

1. Are you currently in a health-related academic program/major?  YES ☐ NO ☐
2. Were you born in, or have you lived, worked or visited for more than one month in any of the following:
   Asia, Africa, South America, Central America or Eastern Europe?  YES ☐ NO ☐
   Reason (please circle) Born there Tourist Work School Other ______________________
3. Have you had HIV infection, AIDS, diabetes, leukemia, lymphoma or a chronic immune disorder?  YES ☐ NO ☐
4. Do any of the following conditions or situations apply to you?
   a) Do you have a persistent cough? (3 weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss?  YES ☐ NO ☐
   b) Have you ever lived with or been in close contact to a person known or suspected of being sick with TB?  YES ☐ NO ☐
   c) Have you ever lived, worked, or volunteered in any homeless shelter, prison/jail, hospital or drug rehabilitation unit, nursing home or residential healthcare facility?  YES ☐ NO ☐

Student Signature ___________________________  Date ___________________________

If you answered no to all of the above questions, skip Section C.

If you answered yes to any of the above questions, your health care provider must complete Section C below.

SECTION C: ATTENTION HEALTH CARE PROVIDER: If patient answered YES to any of the above questions, proof of a PPD, QuantiFERON –TB Gold or T-SPOT is REQUIRED. If PPD results are 10mm or more, or QuantiFERON-TB Gold or T-SPOT are positive a chest x-ray is REQUIRED. Testing and/or chest x-ray must be done within one calendar year prior to admittance (unless history of positive PPD). If student has history of positive PPD, chest x-ray is required. History of BCG vaccination does not prevent testing of a member of a high risk group.

PPD: Date placed ________________  Date read ________________  # of mm induration ________________

QuantiFERON-TB Gold or T-SPOT: Result Date ________________  Result (attach lab report) ________________

Date of chest x-ray ________________  Result ________________

If negative CXR and positive PPD, did student complete a course of INH?  YES ☐ NO ☐
If yes, when ________________ (months & year) and for how many months did student take INH? ________________ (# of months)

SIGNATURE INFORMATION REQUIRED

Signature/Stamp of health care provider ___________________________  Phone number of practice ___________________________  Date ___________________________