Tuberculosis Testing
Clinical Assessment to be completed and signed by a Health Care Provider

Name: _____

Date of Birth: _____ Student ID Number: _____

History of a positive TB skin test or IGRA blood test? **Yes** **No**

History of BCG vaccination? **Yes** **No**

If the answer is yes to either of the above questions, then an IGRA blood test (Quantiferon Gold or TSpot) should be completed and the lab report submitted along with this form.

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes____No _____
If No, proceed to 2 or 3

If yes, check below and proceed to 2 or 3:

- Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- Coughing up blood (hemoptysis)
- Chest pain
- Loss of appetite
- Unexplained weight loss
- Night sweats
- Fever

2. Tuberculin Skin Test (TST)
TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0".

Date Given:____/____/____ Date Read:____/____/____
M D Y M D Y

Result:_____mm of induration **Interpretation: positive____negative_____

***** >10 mm is positive.***

3. Interferon Gamma Release Assay (IGRA) - LAB REPORT REQUIRED

Date Obtained:____/____/____ (specify method) QFT-GIT____T-Spot ___ other___
M D Y

*Result: negative___ positive___ indeterminate___ borderline___

*If result is positive, indeterminate or borderline, a chest x-ray report dated on or after the date of the lab result must be submitted.

CERTIFIED HEALTH CARE PROVIDER – Signature Required:

Name: _____ **Signature:** _____ **Date:**____/___/____

Address: _____ **Phone Number:** _____