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: ________________________