I. **Screen for TB Symptoms (Check all that apply)**

- None (Skip to Section II, “Screen for Infection Risk”)
- Cough for >3 weeks ➔ Productive: ___YES ___NO
- Hemoptysis
- Fever, unexplained
- Unexplained weight loss
- Poor appetite
- Night sweats
- Fatigue

**Pediatric Patients (< 6 years of age):**
- Wheezing
- Failure to thrive
- Decreased activity, playfulness and/or energy
- Lymph node swelling
- Personality changes

Evalue these symptoms in context

II. **Screen for TB Infection Risk (Check all that apply)**

Individuals with an increased risk for acquiring latent TB infection (LTBI) or for progression to active disease once infected should have a TST. Screening for persons with a history of LTBI should be individualized.

A. **Assess Risk for Acquiring LTBI**

The Patient...
- is a current high risk contact of a person known or suspected to have TB disease: Name of Source case:
- has been in another country for - 3 or more months - where TB is common, and has been in the US for ≤ 5 years
- is a resident of or employee of a high TB risk congregate setting
- is a healthcare worker who serves at high-risk clients
- is medically underserved
- has been homeless within the past two years
- is an infant, a child or an adolescent exposed to an adult(s) in high-risk categories
- injects illicit drugs or uses crack cocaine
- is a member of a group identified by the health department to be at an increased risk for TB infection
- needs baseline/annual screening approved by the health department

B. **Assess Risk for Developing TB Disease if Infected**

The Patient...
- is HIV positive
- has risk for HIV infection, but HIV status is unknown
- was recently infected with *Mycobacterium tuberculosis*
- has certain clinical conditions, placing them at higher risk for TB disease:
- injects illicit drugs (determine HIV status):
- has a history of inadequately treated TB
- is >10% below ideal body weight
- is on immunosuppressive therapy (this includes treatment for rheumatoid arthritis with drugs such as Humira, Remicade, etc.)

<table>
<thead>
<tr>
<th>History of BCG / TB Skin Test / TB Treatment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of prior BCG: ___NO ___YES Year: ____</td>
</tr>
<tr>
<td>History of prior (+) TST: ___NO ___YES</td>
</tr>
<tr>
<td>Date of (+) TST: _________________________</td>
</tr>
<tr>
<td>Reading: ____mm</td>
</tr>
<tr>
<td>CXR Date: _______________ CXR result: ___ABN ___WNL</td>
</tr>
<tr>
<td>Dx: ___LTBI ___Disease</td>
</tr>
<tr>
<td>Tx Start: _______________ Tx End: __________</td>
</tr>
<tr>
<td>Rx: _______________</td>
</tr>
<tr>
<td>Completed: ___NO ___YES</td>
</tr>
</tbody>
</table>

III. **Finding(s) (Check all that apply)**

- Previous Treatment for LTBI and/or TB disease
- No risk factors for TB infection
- Risk(s) for infection and/or progression to disease
- Possible TB suspect
- previous positive TST, no prior treatment

IV. **Action(s) (Check all that apply)**

- Issued screening letter ___ and sputum containers
- Referred for CXR ___ Referred for medical evaluation
- Administered the Mantoux TB Skin Test
- Draw interferon-gamma release assay
- Other: ______________________

<table>
<thead>
<tr>
<th>TST Placed</th>
<th>TST Read</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arm: __Left ___Right</td>
<td>Date/Time ______________</td>
</tr>
<tr>
<td>Induration _____mm</td>
<td>POS#: __________________</td>
</tr>
<tr>
<td>POS#: __________________</td>
<td>Reading: ____mm</td>
</tr>
</tbody>
</table>

**IGRA Type used:** ___T-Spot ___QFT-G-IT

Date/Time drawn: ______________
Result: ___Pos ___Neg ___Borderline/Indeterminate

Screeners’ signature: ______________________
Screeners’ name (print): ______________________
Screeners’ title: ______________________
Date: ______________ Phone #: ______________________
Comments: ______________________

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I hereby authorize the doctors, nurses, or nurse practitioners of the Virginia Department of Health to administer the Tuberculin Skin Test (PPD) or draw blood for an IGRA test from me or my child named above.

I agree that the results of this test may be shared with other health care providers.

The Deemed Consent for blood borne diseases has been explained to me and I understand it.

I acknowledge that I have received the Notice of Privacy Practices from the Virginia Department of Health.

I understand that: • this information will be used by health care providers for care and for statistical purposes only.
• this information will be kept confidential.
• medical records must be kept at a minimum for 10 years after my last visit, 5 years after death; for minor children, 5 years after the age of 18, or 10 years after the last visit, whichever is greater.

X __________________________ Date: ______________________

May 2011