

Patient name (L,F,M): _____ DOB: _____ Race: _____ Sex: _____
 Address: _____ Social Security Number: _____
 City, State, ZIP: _____ Home/Work #: _____
 Cell #: _____ Language: _____ Patient Pregnant: ___ No ___ Yes; If Yes, LMP: _____
 Country of Origin: _____ Year arrived in US (if applicable): _____ Interpreter needed: ___ No ___ Yes

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

___ None (Skip to Section II, "Screen for Infection Risk")
 ___ Cough for \geq 3 weeks \rightarrow Productive: ___ YES ___ NO
 ___ Hemoptysis
 ___ Fever, unexplained
 ___ Unexplained weight loss
 ___ Poor appetite
 ___ Night sweats
 ___ Fatigue
Evaluate these symptoms in context

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

History of BCG / TB Skin Test / TB Treatment:

History of prior BCG: ___ NO ___ YES \rightarrow Year: _____
 History of prior (+) TST: ___ NO ___ YES
 Date of (+) TST _____ Reading: _____ mm
 CXR Date: _____ CXR result: ___ ABN ___ WNL
 Dx: ___ LTBI ___ Disease
 Tx Start: _____ Tx End: _____
 Rx: _____
 Completed: ___ NO ___ YES
 Location of Tx: _____

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 \leq 5 years
 ___ is a resident or an employee of a high TB risk congregate setting
 ___ is a healthcare worker who serves 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, Remicaid, etc.)

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 ___ Issued sputum containers
 ___ Referred for CXR ___ Referred for medical Evaluation
 ___ Administered the Mantoux TB Skin Test
 ___ Draw interferon-gamma release assay
 ___ Other: _____

#1 TST Lot# _____ or IGRA (Check One)

Date Given or Drawn _____ Time _____
 Signature _____ POS# _____
TST READING/ IGRA Results Date Read _____
 Time _____ Signature _____ POS# _____
 Induration _____ mm ___ Pos ___ Neg (**TST or IGRA**)
 ___ Borderline/Indeterminate - **IGRA ONLY**

#2 TST Lot# _____ or IGRA (Check One)

Date Given or Drawn _____ Time _____
 Signature _____ POS# _____
TST READING/ IGRA Results Date Read _____
 Time _____ Signature _____ POS# _____
 Induration _____ mm ___ Pos ___ Neg (**TST or IGRA**)
 ___ Borderline/Indeterminate - **IGRA ONLY**

Screener's signature: _____
 Screener's name (print): _____
 Date: _____ Phone #: _____

- 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: _____