VIRGINIA DEPARTMENT OF HEALTH
REPORT OF TUBERCULOSIS SCREENING

Name_____________________________________ Date of Birth_______ Date__________

TO WHOM IT MAY CONCERN: The above individual has been evaluated by: ____________________________

(PLEASE PRINT name of health department, facility or clinician)

TB Screening and/or Testing Conclusions

I. No Symptoms nor Other Risks Identified on TB Risk Assessment

_____ A tuberculin skin test (TST) or blood test (IGRA) is not indicated at this time due to the absence of symptoms suggestive of active TB, no risk factors identified for infection or for developing active TB if infected, and has no known recent contact with active TB. Health care workers employed in a low risk facility according to CDC “Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005” do not need tested.

_____ The individual has a history of TB infection. Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active TB.

If neither applies, go to section II. If in a health-care setting that requires a test for TB infection but no symptoms are present, go to section III. If one of these two statements applies, select the appropriate statement and skip to Section V and select statement ‘A’.

II. Symptoms Consistent with Potential Tuberculosis are Present

Call the local health department to refer the person for further TB evaluation immediately. This notification is necessary even when the individual prefers to pursue and evaluation privately. Proceed to Section V and select statement ‘B.’

If there are no symptoms consistent with TB, go to Section III.

III. Testing for TB Infection – Choose TST or IGRA

| Tuberculin Skin Test (TST): (record both tests if a 2-step TST was required) |
| Date given: ______ Date read: _______ Results: ______mm Interpretation: ___ negative ___ positive |
| Date given: ______ Date read: _______ Results: ______mm Interpretation: ___ negative ___ positive |

| Interferon Gamma Release Assay (TB infection blood test): |
| Date drawn: ______ Date read: _______ Test done: ____ T-Spot TB ____ Quantiferon TB Gold |
| Result: ___ negative ___ positive ___ indeterminate ___ borderline ___ invalid |

If test above is negative, proceed to Section V and select statement ‘A’. If either test for TB infection is positive, proceed to Section IV.

IV. Chest X-Ray to Evaluate for Potential TB Disease

| Date of chest x-ray: ______ Date location of chest x-ray: ________________________________ |
| Interpretation: ___ no evidence of active tuberculosis ___ chest x-ray abnormal, active tuberculosis to be ruled out |

V. TB Screening/Testing Conclusion

_____ A. Based on the TB Screening and/or further testing, the individual listed above is free of communicable tuberculosis in a communicable form.

_____ B. Active tuberculosis cannot be ruled out in the individual listed above. The individual has been referred to their physician and the local health department for further evaluation.

Signature __________________________ Date ___________ Phone __________________

(Clinician with prescriptive authority or health department official)

Address ________________________________________________________________

August 2017