

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 testing.
- \_\_\_\_\_ 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 an 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: _____	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: _____	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 \_\_\_\_\_  
\_\_\_\_\_