

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.
- _____ 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 Plus

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 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 _____