

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: _____ Interpreter needed: No Yes Last Live Vaccine: _____

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

- None (Skip to Section II, "Screen for Infection Risk")
- Cough for \geq 3 weeks → Productive: YES NO
- Hemoptysis
- Fever, unexplained
- Unexplained weight loss
- Poor appetite
- Night sweats
- Fatigue

Evaluate these symptoms in context

Pediatric Patients

($<$ 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 → 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: _____
- lived in or visited another country where TB is common for 3 months or more, regardless of length of time in the U.S.
- 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 testing 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 – includes treatment with TNF- α antagonists (Remicaid, Humira, etc.), other biologic response modifiers or prednisone \geq 1 mo. \geq 15 mg/day

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 _____ Site _____
 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 _____ Site _____
 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 SkinTest (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: _____

Client or Parent/Guardian Signature