RTC RENTON TECHNICAL COLLEGE

TUBERCULOSIS (TB) SCREENING FORM

SELF-ASSESSMENT (TO BE COMPLETED BY PATIENT OR PARENT/GUARDIAN)

Name: Last:_____First:_____Middle:_____Date of Birth:___/___/___

Address:_____
Street Apt. # City State Zip Code

Phone: ( ) _____ ( )_____ ( )_____
Home Cellular Emergency Number

1. Have you ever had a TB skin test? Yes_____ No_____ Don't Know_____
   - If yes, when was it? ____/____/____ Result? Positive____ Negative___Don't Know____
   - If positive, do you have the documentation? Yes_____No_____
2. Did you have a chest x-ray after your skin test? Yes_____No_____
   - If yes, when was it? ____/____/____
   - Where was it? (e.g. name of hospital, doctor, clinic)_____
3. Have you ever been told that you have TB? If so, when was it? ____/____/____
4. Have you ever been treated for TB infection or TB disease? Yes_____No_____
   - Which medicines did you take?_____
   - How long were you on the treatment?_____
     _____

Please indicate your answers in one of the columns to the right	**Yes**	**No**	**Don't Know**
5. Have you ever been told, or suspected, that you were exposed to someone with TB? • If yes, when:____/____/____ Name/Relationship:_____			
6. Have you ever had cancer of the head, neck, or lung: leukemia; or lymphoma?			
7. Have you ever had an organ or tissue transplant?			
8. Are you taking steroids (like prednisone), chemotherapy or drugs that affect your immune system?			
9. Do you have diabetes or high blood sugar?			
10. Do you have any of the following symptoms:			
• Cough longer than 2 weeks? Date when you first noticed____/____/____			
• Fevers, chills, night sweats longer than 2 weeks? Date when you first noticed____/____/____			
• Weight loss that was not planned? Date when you first noticed ____/____/____			
11. Do you have renal failure, or are you on kidney dialysis?			
12. Do you think you are at risk of having HIV infection?			
13. Have you ever injected street drugs?			
14. Were you born outside of the United States? If yes, what country? _____			
15. (If patient under 18) Has anyone who lives with you moved to the U.S. within the last 5 years? If so, which country? _____			
16. Have you had any visitors from outside the U.S.? When?_____ Where were they from?_____			
17. Have you traveled to any other countries recently? Where?_____ How long did you stay?_____			
18. Have you ever lived or worked in a group setting such as a hospital, nursing home, drug treatment center, homeless shelter, jail, or prison?			

If you answered "Yes" to any of the questions from 5 to 18, you may be at increased risk of having TB infection or developing active TB. If you answered "No" to all, you are not considered at higher risk for TB.

_____
Patient or Parent/Guardian Signature

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TB TWO –STEP OR BLOOD TEST ASSESSMENT OUTCOME ADMINISTRATION (TO BE COMPLETED BY CLINICIAN)

Prior Documentation (or convincing history) of TB or LTBI:

_____ No TB test needed. *Patient may still need evaluation for treatment for LTBI or active TB*

TB Risk Category (check only one):

_____ **Medical risk factor (includes contacts to active TB cases)** (questions 5-12)

_____ **Population risk factor** (questions 13-18)

_____ **Administrative** (TB test required only for work, school, etc.)

Option 1: TB 2-Step

2 Step Testing for Health Care Workers (*This includes Nursing and Allied Health Students & Faculty)*

STEP ONE AND TWO MUST BE READ 48-72 HOURS FOLLOWING ADMINISTRATION

STEP ONE

1St TST Mantoux Test Date: _____/_____/_____ **Tuberculin lot number: _____** **Expiration date: _____/_____/_____**

Date interpreted: _____/_____/_____ Result: _____mm Positive_____ Negative_____

STEP 2 MUST BE COMPLETED WITHIN 7-21 Days

STEP TWO

2nd TST Mantoux Test Date: _____/_____/_____ **Tuberculin lot number: _____** **Expiration date: _____/_____/_____**

Date interpreted: _____/_____/_____ Result: _____mm Positive_____ Negative_____

Option 2: IGRA –TB Blood Test

Screening Test: _____Blood Test (QuantiFERON TB Gold**)**

Blood Test IFN concentration: _____ IU/ml Result: Positive_____ Negative _____ Indeterminate_____

Only if option 1 or 2 return positive results

PHYSICAL EXAM: Date: _____/_____/_____ No signs of TB _____ **or** Abnormal, Suggested TB _____

CHEST X-RAY: Date: _____/_____/_____ Reading:_____

OUTCOME (check only one):

_____LTBI treatment prescribed
_____No treatment needed (not infected)
_____No treatment indicated (low TB risk)
_____Treatment deferred due to _____
_____Patient being evaluated as a TB suspect
_____Patient refused treatment
_____Treatment not advised due to high risk of hepatitis
_____Previously treated for TB or LTBI
_____Other_____

Follow-up/Comments (include treatment regimen):

_____
Provider Signature

_____ _____
Provider Name (please print) Date