**Clark University Health Services**

**Tuberculosis Screening**

Name (Last, First):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year Entered:\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clark Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clark ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year arrived in US: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Please answer the following questions then sign and date the student portion of this form**

 1. Have you ever had Tuberculosis? □ Yes □ No

2. Have you ever had a positive PPD, TB QuantiFERON test, or T-SPOT? □ Yes □ No

3. Were you born in, lived, worked, or visited for more than 1 month any of the following areas? Africa, Asia, Central America, Eastern Europe, South America □ Yes □ No If yes, what country? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Have you ever had close contact with person(s) known or suspected to have active TB disease? □ Yes □ No

5. Have you ever been a resident, volunteer, and/or employee in a correctional facility, long-term care facility, hospital or drug rehabilitation unit, or homeless shelter? □ Yes □ No

6. Have you been diagnosed with HIV infection, AIDS, leukemia, lymphoma, or a chronic immune disorder? □ Yes □ No

7. Do you have a persistent cough (3 weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss? □ Yes □ No

 Student signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If the answer is **YES** to any of the above questions, you are required to have your healthcare provider complete the information below. If the answer to all questions above is **NO**, no further testing is required.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**To be completed by healthcare provider**

*If patient answered YES to any of the above questions one of the following is required: PPD or QuantiFERON-TG Gold or T-SPOT.*

PPD Placed Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ PPD Reading Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result # of mm induration: \_\_\_\_\_\_\_\_\_\_\_\_\_

***OR***

QuantiFERON-TB Gold or T-SPOT Result Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result (attach lab report): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*A chest x-ray is required if PPD results are 10mm or more or QuantiFERON-TB Gold or T-SPOT are positive.*

Date of chest x-ray: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_ □ Normal □ Abnormal

*If negative chest x-ray and positive PPD did student complete treatment?* □ Yes □ No □ Declined

Prophylactic medications:

Medication Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Started: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Healthcare Provider Information (Required)**

Healthcare provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NP, PA, MD, DO

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Healthcare provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_