

TB SCREENING FORM

	SF DEP	ARTMENT OF PUBLIC HEALTH	NAME:			BIRTH	HDATE:	
⇒ Tell u	JS THE RE	EASON(s) FOR YO	OUR TB SCREE	NING TOD	AY (CHECK AL	L THAT APPLY)		
		work or school. (6				<u> </u>		
☐ Other rea		,	, ,					
		R THE FOLLOWING	G OUESTIONS:					
				∏Yes □No	Take any me	edications?		
□Yes □No		you born or rais	ed outside the	USA!	If yes, list:	rake any mi	edications.	
If Yes ⇒		ry of Birth			17 700, 1100			
		entered the USA			∏Yes □No	Have any medical conditions?		
	Receiv	ved BCG* vaccine?			If yes, list:	,		
	Year o	of last BCG]N/A				
* BCG = a TB va	ccine given i	n some countries (but n	ot in the USA)	∏□Yes □No	Have a cond	lition or take a medicin	e	
Date of Most Recent TI					+-	that weakens the immune system?		
mo / day/ yr	Type of		□Skin test □Blood (Quantiferon)		∏ □Yes □No	Currently p	regnant?	
□Never had	Туре	or test			∥□Yes □No	Faint or get l	ightheaded with needles	?
□Don't know	/				∥□Yes □No	=	nedications or vaccines	
					If yes, list:	J		
☐Yes ☐No Ever had a Positive** TB test?								
If Yes ⇒		of Positive TB test	□Skin test					
	Type o	of test			Have you ever:			
			□Blood (Quant	uteron)	∏Yes □No		ith, or treated for TB?	
** Positive TB Skin Test = Raised bump at test site; told by health care professional it was TB positive, usually requires a Chest X-Ray.					† □Yes □No	Yes □No Had contact with, or lived with someone sick with active TB?		
was 15 positive, usually requires a Criest A-ray.					☐Yes ☐No Lived or worked in a refugee camp,			
□Yes □No	Ever	had a Chest X-Ra	ıy for TB?			homeless sh	· ·	
If Yes ⇒	Year c	of Chest X-Ray			∏ □Yes □No		th care worker?	
Resu			☐Active TB		∏Yes □No	Traveled to the developing world and had close contact with the local		.
			□Not Active TB			population? If yes, describe:		
						population	., , , , , , , , , , , , , , , , , , ,	
□Yes □No	Ever	taken INH (Isonia	azid) for TB?					
If Yes ⇒	,	ou took INH			11 -	<u>e these sympto</u>		
	Numb	er of months taken			∥□Yes □No	Cough lastir	ng more than 3 weeks?	
			vaccines in the last 28d?		∏□Yes □No	Coughing up	blood?	
□Yes □No	паче	you received any			∏□Yes □No	Unintention	al weight loss?	
				∏ □Yes □No	Loss of appe	etite?		
					∏ □Yes □No	Fever?		
					∏Yes □No	Sweating at	night?	
⇒ AITC	STAFF U	JSE ONLY						
	Step TST	☐ 2-Step TST	☐ QFT-IT Gold	1	☐ Symptom	Review Only (skip	to p. 2)	
Step Date P	Placed	Site Lot #	Placed By	,	Date Read	Result	Read By	
#I		R L				mm	,	
#2		R L				mm		
ASSESSMENT:				PLAN:				
☐ Pos ☐ Neg State TB Risk Asse		State TB Risk Assessr	nent State Certificate Comp		ficate Completed	☐ Yellow Card w/Re	esult TB-47 Given	
☐ Yes ☐ No	_		(s)	☐ CXR Referral Form		☐ Education per Pro	otocol	
☐ Yes ☐ No		AITC TB Symptoms						
□ Pos □ Neg □ Ind TST Step #I			☐ Other Referral To:		For:			
☐ Pos ☐ Neg		TST Step #2						
☐ Pos ☐ Neg	\square Neg \square Ind QFT-IT Gold Clinician S		Signature:		Date:			



TB SCREENING FORM - continued

History of LTBI

⇒ Al	1631	AFF USE (ONLT							
TB Testi	ng	(list dates, test types, findings)								
CXR		(list dates, findings, esp. most recent CXR)								
Sx Review		\square Positive for Sx		☐ Negative for Sx						
LTBI Tx		·		pletion Documented (Attach Copy of Documentation) completed, Not Documented, or Documentation Unavailable						
									Congrega	ate
Exposure	•	□ Yes □	No	Recent (since last TB eval) exposure to Active TB Case						
Risk Fact	ors		No	HIV or other significant immune compromise due to illness or medication						
			No	TB test conversion within past 2 years						
		☐ Yes ☐	No	On immune modulator therapy for autoimmune disease						
		□ Yes □	No	End Stage Renal Disease, silicosis, jejuno-ileal bypass, or head/neck carcinoma						
		□ Yes □	No	Old inactive TB on prior CXR						
		☐ Yes ☐		Diabetes, gastrectomy, IV drug use, or malnutrition						
DISPOSI	TION									
	A) Ok	A) Ok to clear								
□ (I	(B) Provider Visit and CXR									
	(C) Ok to clear; Watch for New TB Symptoms; See provider for F/U and consideration of INH if no previous Tx or Treatment incomplete									
□ (I	(D) Consult SFTBC by phone and follow recommendations									
□ (I	(E) Provider Visit and CXR; Consult SFTBC by phone									
Referral To:										
Clinician Signature:										