County of Fresno

DEPARTMENT OF PUBLIC HEALTH

David Luchini, Director

Dr. Rais Vohra, Interim Health Officer

Tuberculosis (TB) Screening Form

Name: _____ **Date of Birth:** _____

Please answer the following questions:		
Section 1	**Have you ever had a positive TB test?** Year of test: _____ Type of test: ☐ Skin test ☐ Blood test	☐ Yes ☐ No
	Have you ever taken medications for TB infection? Year taken: _____ List medications taken:	☐ Yes ☐ No
	Have you received any vaccines within the last 28 days? List vaccines:	☐ Yes ☐ No
Section 2	**Have you ever received the BCG* vaccine?** **BCG is a TB vaccine given in some countries outside of the United States. A TB blood test with your primary care provider is recommended for individuals who have received BCG vaccine.*	☐ Yes ☐ No
	Have you spent at least 1 month in a country with elevated risk* for TB, this includes birth, travel, or residence? **Countries with increased risk include any country except the United States, Canada, Australia, New Zealand, or a country in western or northern Europe.* If yes, what country?: _____ What year did you leave that country?: _____	☐ Yes ☐ No
	Do you have any of the following symptoms? ☐ Cough lasting longer than 2 weeks ☐ Coughing up blood ☐ Unexplained weight loss or loss of appetite ☐ Fever or chills ☐ Night sweats ☐ Excessive fatigue	☐ Yes ☐ No
Section 3	**Have you tested positive for HIV infection or are you at risk for HIV infection?**	☐ Yes ☐ No
	Do you have a suppressed immune system caused by a condition or take a medicine that weakens the immune system, such as any of the following? ☐ Taking medications that suppress the immune system such as TNF-alpha antagonist medications (e.g., infliximab, etanercept, others) or steroids ☐ Organ or tissue transplant; cancer of the head, neck or lung; leukemia; or lymphoma	☐ Yes ☐ No
	Have you ever been a close contact to someone with infectious TB disease? If yes, when? _____ (month/year) Did this person live in the same house with you? ☐ Yes ☐ No	☐ Yes ☐ No
	Have you had an abnormal chest X ray before that suggested TB disease? If yes, when?: _____ (month/year) Do you have a copy of the results? ☐ Yes ☐ No	☐ Yes ☐ No

CLINIC USE ONLY

Review screening form on day of TST placement.

Registration form:

Patient has insurance: ☐ Yes ☐ No

Patient has a primary care provider: ☐ Yes ☐ No

Child is **under 5 years** of age: ☐ Yes ☐ No

Section 1:

☐ *NO's* only. Okay to proceed with TST placement today.

☐ *YES* and/or live vaccine within 28 days. Do not place TST today.

Section 2:

☐ No history of BCG vaccine.

☐ Yes, patient received BCG vaccine. Education provided to patient that blood test is preferred as BCG may cause false positive TST.

Section 3:

☐ *No*'s only. TST will be interpreted as positive if 10mm or greater.

☐ *Yes*'s present. TST will be interpreted as positive if 5mm or greater.

Reviewer's signature: | Date:

If TST is positive, complete this section.

Measuring of TST: Date placed: _____ Date read: _____ Result: _____mm Measured by: _____

Interpretation of TST: ☐ Positive ☐ Negative Result interpreted by: _____ Date: _____

1) Determine if TB Clinic referral needed.

Does patient meet criteria to be referred to TB Clinic?
(Patients under 5 years of age who are born in US (ie, no prior BCG) must be referred to TB Clinic--send CMR to TB Clinic and call TB staff nurse).

☐ Yes. CMR sent to TB Clinic and TB Staff Nurse notified.

☐ No. IZ Clinic will proceed with steps 2-6 noted below.

2) CXR Order signed by MD and provided to family.

☐ **CXR order is delayed:**
1. Family is advised to return for the CXR order on: _____ (date).
2. CXR order form and TB screening form placed in TB Program area for MD review & signature.
3. Signed CXR order and imaging referral list placed at IZ reception prior to family's scheduled return date (noted in #1).

☐ **Signed CXR order and imaging referral list given to family** on: _____(date).
- Appointment to review CXR results: _____ (date/time).

3) CXR results signed by MD.

☐ **CXR results received from imaging facility and placed in TB Program**, with TB Screening form attached, for MD signature.

☐ **Signed CXR returned to IZ Clinic** and ready for scheduled appointment.

4) School clearance determined.

Does patient meet criteria for school clearance?
(Patient must have a clear CXR and NO symptoms suggestive of active TB disease to receive school clearance.)

☐ Yes, patient meets criteria to receive clearance.

☐ No. Clearance not given, nurse to discuss next steps with FCDPH provider.

5) Documents provided to patient.

☐ **Copies of documents provided to patient** on: _____(date).
- Signed CXR
- Referral to PCP form
- Provider referral list
- School clearance (if applicable)

☐ **Patient has not returned for documents** despite contact attempts.

6) Save record.

☐ **Documents saved** per IZ practices.