Tuberculosis Targeted Testing

Louisiana R.S. 17:170/Schools of Higher Learning

Last Name: _____ First Name: _____ MI: _____ Date of Birth: _____

Section One: Questionnaire

Please answer the following questions:	Yes	No
1. Have you traveled in the past 5 years or lived more than 6 weeks in Africa, East Europe, Asia, Middle East, or South/Central America?		
2. Do you have a personal history of cancer, leukemia, kidney disease, diabetes, alcoholism, or intravenous drug use? (Family history does not apply)		
3. Have you been a resident, employee, or volunteer in a prison, nursing home, homeless shelter, hospital, or long-term treatment facility?		
4. Have you ever been vaccinated with BCG Tuberculosis vaccination?		
5. Do you have AIDS/HIV or take medications that suppress the immune system such as prednisone?		
6. Have you ever had close contact with persons known or suspected to have active TB disease?		
7. Have you ever tested positive for TB?		

If the answer to all of the above questions is NO, sign below and return this document to the appropriate admissions office.

Signature: _____ Date: _____

If the answer is YES to any of the above questions, NOBTS requires results of TB testing within the past year. A healthcare provider should complete section two of this form below.

Section Two: Test Results

Step 1: Tuberculin Skin Test--Positive if ≥ 10mm for questions 1, 2, 3, or 4 or ≥ 5mm for questions 5 or 6.

Date Given: _____ Date Read: _____ Result: ____mm of induration Interpretation: Positive____ Negative ____

Step 2: A QFT or T-SPOT is required if PPD is positive. A Chest X-Ray will not be accepted in its place. (Please provide a copy of results.)

Date obtained: _____ Circle Method Given: QFT T-SPOT Result: Positive ____ Negative: ____

Step 3: Students with a positive QFT or T-SPOT should receive a Chest X-Ray.

Date of X-Ray: _____ Result: Normal ____ Abnormal: ____

Step 4: Students with a positive QFT or T-SPOT with no signs of active disease on chest X-Ray are recommended to be treated for Latent TB with appropriate medication.

Name of medication for treatment: _____

Date initiated and duration of treatment: _____

Please provide a copy of completion of treatment.

_____ Student has been treated or agrees to receive treatment.

_____ Student declines treatment at this time and agrees to routine checkups to monitor progression of Latent TB.

Name of Health Care Provider (Print): _____ Address: _____

Signature of Health Care Provider: _____ Date: _____