



Tuberculosis Screening Form

To be completed by a physician or public health department

Name: _____ Date of Birth: _____ Country of Birth: _____

If patient has had a history of positive PPD, please proceed directly to #2

1. Report of TB Skin Test: (TST/Mantoux)
Within the past 12 months

Date Administered: ___/___/___

Date Read: ___/___/___

Result: ___ mm induration

Negative/Positive (please proceed to next section)

*For a reference for interpretation of mm induration reads please visit <http://www.cdc.gov/tb/pubs/tbfactsheets/skintesting.htm>

2. History of Positive TB (TST) Skin test:

Date Administered: ___/___/___

Date Read: ___/___/___

Result: ___ mm induration

Please proceed to next section

Please provide one of the following if you have or have had a Positive TST Test:

Chest X-ray

Date of X-ray ___/___/___

If Chest X-ray is over 12 months old please proceed to #3.

Result: Normal/Abnormal
(please circle one)

*Abnormal denotes signs consistent with active or old TB. If abnormal, please include radiology report and proceed directly to #4

QuantiFERON Gold or T-Spot Test
(interferon gamma release assay blood testing)

Name of Test: _____

Date of blood test: _____

Result: Positive / Negative
(please circle one)

If positive: Chest X-ray is required and therapy is recommended.

If negative: No X-ray or therapy required, proceed directly to signature portion of form.

3. Chest X-rays over 12 months old:

If last Chest X-ray did not show evidence of active TB, have there been any **NEW** risks for TB exposure, including residence or greater than 1 month stay in a country with high TB rates? (circle one)

Yes / No If Yes, what risks? _____

If Yes, can you verify that a subsequent Chest X-ray was performed within 90 days of arrival at Dartmouth which did not show evidence of active TB? (circle one)

Yes / No If Yes, please provide date if known: _____

4. Treatment of Active or Latent TB Infection: (if applicable)

Has this patient completed treatment for active or latent TB infection?
(circle one)

Yes / No

If Yes, please give details:

Authorized Signature:

Physician/Health Department (print name) _____

Authorized Signature: _____ Date: ____/____/____

Address/ Telephone: _____

Additional Information regarding TB testing criteria and procedures is available at the Center for Disease Control Website <http://www.cdc.gov/vaccines/vpd-vac/tb/default.htm>