Part I: Tuberculosis (TB) Screening Questionnaire

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease?  
☐ Yes    ☐ No

Were you born in one of the countries listed below with a high prevalence of TB disease?  
(If yes, please check the country, below)

- Afghanistan
- Algeria
- Angola
- Argentina
- Armenia
- Azerbaijan
- Bahrain
- Bangladesh
- Belarus
- Belize
- Benin
- Bhutan
- Bolivia
- Bosnia and Herzegovina
- Botswana
- Brazil
- Brunei Darussalam
- Bulgaria
- Burkina Faso
- Burundi
- Cabo Verde
- Cambodia
- Cameroon
- Central African Republic
- Chad
- China
- Colombia
- Comoros
- Congo
- Côte d'Ivoire
- Democratic People's Republic of Korea
- Democratic Republic of the Congo
- Djibouti
- Dominican Republic
- Ecuador
- El Salvador
- Equatorial Guinea
- Eritrea
- Estonia
- Ethiopia
- Fiji
- Gabon
- Gambia
- Georgia
- Ghana
- Guatemala
- Guinea
- Guinea-Bissau
- Guyana
- Haiti
- Honduras
- India
- Indonesia
- Iran (Islamic Republic of)
- Iraq
- Kazakhstan
- Kenya
- Kiribati
- Kuwait
- Kyrgyzstan
- Lao People's Democratic Republic
- Latvia
- Lesotho
- Liberia
- Libya
- Lithuania
- Madagascar
- Malawi
- Malaysia
- Maldives
- Mali
- Marshall Islands
- Mauritania
- Mauritius
- Mexico
- Micronesia
- Mongolia
- Morocco
- Mozambique
- Myanmar
- Namibia
- Nauru
- Nepal
- Nicaragua
- Niger
- Nigeria
- Niue
- Pakistan
- Palau
- Panama
- Papua New Guinea
- Paraguay
- Peru
- Philippines
- Poland
- Portugal
- Qatar
- Republic of Korea
- Republic of Moldova
- Romania
- Russian Federation
- Rwanda
- Saint Vincent and the Grenadines
- Sao Tome and Principe
- Senegal
- Serbia
- Seychelles
- Sierra Leone
- Singapore
- Solomon Islands
- Somalia
- South Africa
- South Sudan
- Sri Lanka
- Sudan
- Suriname
- Swaziland
- Tajikistan
- Thailand
- Timor-Leste
- Togo
- Trinidad and Tobago
- Tunisia
- Turkey
- Turkmenistan
- Tuvalu
- Uganda
- United Kingdom
- United Republic of
- Tanzania
- Uruguay
- Uzbekistan
- Vanuatu
- Venezuela
- Viet Nam
- Yemen
- Zambia
- Zimbabwe

Have you visited one or more of the countries listed above with a high prevalence of TB disease for a period greater than 4 weeks? (If yes, CHECK the countries, above)

☐ Yes    ☐ No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?

☐ Yes    ☐ No

Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?

☐ Yes    ☐ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol?

☐ Yes    ☐ No

If the answer is YES to any of the above questions, University Health Services requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester. Please have Part II (below) completed by a healthcare provider.

If the answer to all of the above questions is NO, no further testing or further action is required. Please sign here and submit this page only to University health Services.

Signature: ___________________________     Date: ________________
Part II. Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented. A chest X-ray alone cannot be used to test for TB exposure, it is only indicated if a TST or IGRA is positive.

History of a positive TB skin test or IGRA blood test? (If yes, document below)   Yes _____ No _____

History of BCG vaccination? (If yes, consider IGRA if possible.)   Yes _____ No _____

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease?   Yes _____ No _____

If No, proceed to 2 or 3

If yes, check below:

- Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- Coughing up blood (hemoptysis)
- Chest pain
- Loss of appetite
- Unexplained weight loss
- Night sweats
- Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write “0”. The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____  Date Read: ____/____/____

M     D       Y                  M     D       Y

Result: ________ mm of induration          **Interpretation:  positive____ negative____

Date Given: ____/____/____  Date Read: ____/____/____

M     D       Y                  M     D       Y

Result: ________ mm of induration          **Interpretation:  positive____ negative____

**Interpretation guidelines

>5 mm is positive:
- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:
- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:
- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.
3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____  (specify method)  QFT-GIT  T-Spot  other____

M  D  Y

Result: negative___  positive___  indeterminate___  borderline___ (T-Spot only)

Date Obtained: ____/____/____  (specify method)  QFT-GIT  T-Spot  other____

M  D  Y

Result: negative___  positive___  indeterminate___  borderline___ (T-Spot only)

4. Chest x-ray: (Required if TST or IGRA is positive, cannot be used as sole indicator for TB infection)

Date of chest x-ray: ____/____/____  Result: normal____  abnormal____

M  D  Y

Part III. Management of Positive TST or IGRA

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

☐ Infected with HIV
☐ Recently infected with *M. tuberculosis* (within the past 2 years)
☐ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
☐ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
☐ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
☐ Have had a gastrectomy or jejunoileal bypass
☐ Weigh less than 90% of their ideal body weight
☐ Cigarette smokers and persons who abuse drugs and/or alcohol

*Populations defined locally as having an increased incidence of disease due to *M. tuberculosis*, including medically underserved, low-income populations

______ Student agrees to receive treatment
______ Student declines treatment at this time

_________________________________________________________          ______________________________
Health Care Professional Signature                                                                                         Date

Print provider name: ___________________________________________

Provider address: ______________________________________________          Phone: _______________________________________