Tuberculosis (TB) Risk Factor Screening

EITHER ITEM A OR B MUST BE COMPLETED BY PHYSICIAN / HEALTHCARE PROVIDER. FORM WILL BE RETURNED IF NEITHER ARE COMPLETED.

Patient/Student Name: _____

☐ **A:** **IGRA: Date:** ____/____/_____ **Results** _____

TST (Mantoux): **Placed:** ____/____/_____ **Read:** ____/____/_____ **Result:** _____(in mm)

IGRA or Test interpretation ☐ **Negative** ☐ **Positive (Please complete reverse side of form)**
(See reverse for TST administration, reading, and interpretation guidelines).

Note: If patient/student has a medically documented previous IGRA or TST, the test need not be repeated unless the individual has **new risk factors** since the last test.

Please document these results above and **complete the form on the reverse side for any positive results**.

Universal Interferon Gamma Release Assay (IGRA) or tuberculin skin (TST) testing is not recommended in the U.S. and other low-incidence countries due to the high rate of false positive results. IGRA testing or TST is indicated for children/individuals with the following risk factors for TB:

1. History of **exposure to anyone with infectious TB** during lifetime or since last IGRA test or TST
2. History of **birth, travel, or residence of ≥1 month in a country with a high TB rate** (Any country other than the United States, Canada, Australia, New Zealand, or those in western or northern Europe)*
3. **Current or planned immunosuppression** including HIV, organ transplant recipient, treatment with a TNF-alpha antagonist, (e.g. infliximab, etanercept, or other), chronic steroids (equivalent to ≥15 mg/day for ≥1 month) or other immunosuppressive medication,
4. **New risk factors** since the last IGRA or TST was performed

* See WHO 2021 Data at **https://data.worldbank.org/indicator/SH.TBS.INCD**
for country specific TB case rates. Case rates of >10/100,000 are considered high incidence TB rates.

☐ **B:** **IGRA or TST screening not indicated**
(Individual has none of the above risk factors)

Healthcare Provider Signature: _____ **Date:** ____/____/_____
(Required)

Telephone:_____ **Fax:** _____

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Medical Evaluation for Latent Tuberculosis Infection

To be completed and signed by a licensed healthcare provider
for all patients with a previous or current (+) IGRA or TST

Patient/Student Name: _____

Tuberculin Skin Test (Mantoux/Intermediate PPD) must be read by a **healthcare provider** 48-72 hours after administration. If there is no induration, indicate "0" under results. Tine or Mono-Vac tests are **not acceptable.**

TST Interpretation Guidelines

See https://www.cdc.gov/tb/webcourses/course/chapter3/3_testing_for_tb_disease_and_ltbi_3_mantoux_tuberculin_skin_test_interpreting_tst_reactions_chart.html for details

Risk Factor	Positive Result
Close contact with case of TB / is immunocompromised/ has fibrotic CXR findings	5 mm or more
Birth, travel, or residence in country with a high rate of tuberculosis*/Children <5 y/o/ IDUs/TB lab workers/residents or staff of high risk congregate settings, diabetics, severe kidney disease,	10 mm or more
No risk factors (**TST should not be performed**)	15 mm or more (if TST done)

B. If IGRA or TST is positive, now or previously, the following are required:

1. **Date of Positive IGRA or TST** **Date:** ____/____/____
2. **Chest X-ray:** (Please attach copy of report) **Date:** ____/____/____

☐ **Normal**

☐ **Abnormal** _____
(Describe)

3. Clinical Evaluation:

☐ **Normal**

☐ **Abnormal** _____
(Describe)

4. Treatment:

☐ **No** _____
(Please explain)

☐ **Yes** _____
(Drug, Dose, Frequency, Dates)

Healthcare Provider Signature: _____ **Date:** ___/____/____
(Required)

Telephone:_____ **Fax:**_____

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