

# Tuberculosis Screening Form

SUNY Polytechnic Institute

This questionnaire must be completed annually by all students in clinical settings. An initial negative 2 step TB test or Interferon Gamma Release Assay must be on file before the screening form can be used annually. Testing should only be performed if the individual answers "yes" to one of the screening questions. Both screening and testing are available at the local health department or your provider.

Note to health care professionals: A negative risk and symptom screen should be considered a negative tuberculosis test in such individuals, and no further testing is required. An Interferon Gamma Release Assay is preferred over a tuberculin skin test for otherwise low-risk individuals with a positive response to the risk or symptom screening questionnaires. (See page 2.)

| Last name (print clearly) | First name | Middle | Date of Birth |
|---------------------------|------------|--------|---------------|
|                           |            |        |               |

### Tuberculosis Risk Questionnaire

|  |            |           |
|--|------------|-----------|
| 1) Were you born outside the USA in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?  | <b>YES</b> | <b>NO</b> |
| 2) Have you traveled outside the USA and lived for more than one month in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?  | <b>YES</b> | <b>NO</b> |
| 3) Do you have a compromised immune system such as from any of the following conditions: HIV/AIDS, organ or bone marrow transplantation, diabetes, immunosuppressive medicines (e.g. prednisone, Remicade), leukemia, lymphoma, cancer of the head or neck, gastrectomy or jejeunal bypass, end-stage renal disease (on dialysis), or silicosis? | <b>YES</b> | <b>NO</b> |
| 4) Have you ever done one of the following: used crack cocaine, injected illegal drugs, worked or resided in jail or prison, worked or resided at a homeless shelter, or worked as a healthcare worker in direct contact with patients?  | <b>YES</b> | <b>NO</b> |
| 5) Have you ever been exposed to anyone with infectious tuberculosis?  | <b>YES</b> | <b>NO</b> |

### Tuberculosis Symptom Questionnaire

| <b>Do you currently have any of the following symptoms?</b>           |            |           |
|---|------------|-----------|
| 1) Unexplained cough lasting more than 3 weeks?                       | <b>YES</b> | <b>NO</b> |
| 2) Unexplained fever lasting more than 3 weeks?                       | <b>YES</b> | <b>NO</b> |
| 3) Night sweats (sweating that leaves the bedclothes and sheets wet)? | <b>YES</b> | <b>NO</b> |
| 4) Shortness of breath?   | <b>YES</b> | <b>NO</b> |
| 5) Chest pain?  | <b>YES</b> | <b>NO</b> |
| 6) Unintentional weight loss?   | <b>YES</b> | <b>NO</b> |
| 7) Unexplained fatigue (very tired for no reason)?                    | <b>YES</b> | <b>NO</b> |

**The above health statement is accurate to the best of my knowledge. I will contact my health care professional and/or the health department if my health status changes.**

|            |       |
|------------|-------|
| Signature: | Date: |
|------------|-------|

### Screening administered by licensed health care professional:

|                            |       |
|----------------------------|-------|
| Printed name and location: |       |
| Signature:                 | Date: |

**Tuberculosis Testing Form**  
SUNY Polytechnic Institute School of Nursing

**Record of Tuberculosis Test**

| Last name (print clearly) | First name | Middle | Date of birth |
|---------------------------|------------|--------|---------------|
|                           |            |        |               |

**Type of test:**

Tuberculin

|            |   |
|------------|---|
| Date given |   |
| Date read  |   |
| Results    | MM reading: _____<br><br><input type="checkbox"/> Negative<br><br><input type="checkbox"/> Positive |

Interferon Gamma Release Assay

|         |  |
|---------|--|
| Date    |  |
| Results |  |

|           |
|-----------|
| Comments: |
|-----------|

| Signature of Authorized Health Professional | Date | Location |
|---|------|----------|
|   |      |          |