



TUBERCULOSIS (TB) EVALUATION FORM

PLEASE SUBMIT FOR CLEARANCE REQUEST FOR PATIENTS HAVING POSITIVE TB INFECTION



NAME	_____	DOB:	_____
HOME ADDRESS:	_____	ETHNICITY:	_____
MAILING ADDRESS:	_____	PHONE NUMBERS:	_____
(Home/Work/Mobile)			

PPD SKIN TEST	Date given: _____	Date read: _____	Result: _____	Reading: _____ mm
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IGRA TEST	Date given: _____	Test Type: _____	Result: _____
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Has the patient been exposed to active TB in the last (2) years? Yes No

SYMPTOMS ≥ 2 WEEKS	YES	NO		DOES THE PATIENT HAVE A HISTORY OF:					
Cough				Cancer	Yes	No	Type:	_____	
Fever				Hepatitis	Yes	No			
Weight loss				Kidney Disease	Yes	No	On dialysis?	Yes	No
Night sweats				Rheumatoid Arthritis (Joint Pain)	Yes	No			
Fatigue				HIV/AIDS	Yes	No	On medications?	Yes	No
Chest pain				Other/Note: _____					
Shortness of breath									
Hoarseness									

If response is "yes" to any of the symptoms or CXR is abnormal, patient will need a repeat (2) view CXR or follow the Radiologist' recommendations before referral to Public Health for clearance

Chest X-ray		
(copy of report MUST be attached)	Date of CXR: _____	Normal Abnormal
Comments: _____		
REPEAT CXR		
(if applicable, copy of report MUST be attached)	Date of CXR: _____	Normal Abnormal
Comments: _____		

NOTE: If active TB is suspected, refer by call or email to the Tuberculosis/Hansen's Disease Control Program

LTBI TREATMENT:	3HP	INH	RIF	Other: _____
Date Started: _____		Date Completed: _____		
Refused		Date Refused _____	Reason for refusing: _____	
Adverse reactions to LTBI therapy? Yes No				

By signing this form, I, _____ (Name of licensed provider (MD/NP/PA)), am certifying that I have ruled out active TB and the patient is cleared for work/school.

NAME OF CLINIC

PHYSICIAN SIGNATURE/STAMP

Date (valid 90 days)