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
IGRA TEST	Date given:_____	Test Type: _____	Result: _____	

Has the patient been exposed to active TB in the last (2) years? ☐ *Yes* ☐ *No*

SYMPTOMS ≥ 2 WEEKS	**YES**	**NO**
Cough		
Fever		
Weight loss		
Night sweats		
Fatigue		
Chest pain		
Shortness of breath		
Hoarseness		

DOES THE PATIENT HAVE A HISTORY OF:

Cancer ☐ Yes ☐ No Type: _____

Hepatitis ☐ Yes ☐ No

Kidney Disease ☐ Yes ☐ No On dialysis? ☐ Yes ☐ No

Rheumatoid Arthritis (Joint Pain) ☐ Yes ☐ No

HIV/AIDS ☐ Yes ☐ No On medications? ☐ Yes ☐ No

Other/Note: _____

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)***

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
BUREAU OF COMMUNICABLE DISEASE CONTROL
TUBERCULOSIS/HANSEN'S DISEASE CONTROL PROGRAM
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Revised and effective: August 01, 2020

CLEAR FORM

LATENT TUBERCULOSIS INFECTION (LTBI)
QUESTIONNAIRE

PLEASE SUBMIT FOR CLEARANCE REQUEST FOR PATIENTS HAVING POSITIVE TB SKIN TEST

NAME		**DOB** _____/_____/_____
ADDRESS		
ETHNICITY		**PHONE NUMBERS: (HOME/WORK/MOBILE)**

PPD SKIN TEST	Date given:	Date read:	Results: _____mm
Chest X-Ray (Copy of report **MUST** Be Attached)	Date of CXR exam:	☐ Normal ☐ Abnormal	Comments: _____ _____
LTBI Treatment	Date treatment started:	Date completed:	☐ No h/o treatment
	Adverse reactions to LTBI therapy? ☐ YES ☐ NO		Patient declined therapy? ☐ YES ☐ NO

Have you been exposed to active TB? ☐ YES ☐ NO

SYMPTOMS	YES	NO
Cough		
Fever		
Weight loss		
Night sweats		
Fatigue		
Chest pain		
Shortness of breath		
Hoarseness		

If response is "yes" to any of the symptoms, patient will need a repeat 2 view CXR before referral to Public Health for clearance.

Please include findings from repeat CXR (Copy of report **MUST** be attached**):**

☐ Normal
☐ Abnormal

Patient is cleared for work/school	☐ Yes	☐ No
Patient is referred to the Department of Public Health Communicable Disease Clinic for possible active tuberculosis **(All required documents MUST accompany referral**).	☐ Yes	☐ No

Physician Signature/Stamp **Name of Physician/Clinic** **Date (Valid 90 days)**

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
BUREAU OF COMMUNICABLE DISEASE CONTROL
TUBERCULOSIS/HANSEN'S DISEASE CONTROL PROGRAM
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