**SUPPLEMENTAL TB SCREENING FORM**

***Completed form must be uploaded through the Patient Gateway by July 3, 2024***

* **MUST be completed if you answered YES to any of the TB Screening Questions**
* **MUST attach documentation of any skin/blood testing, chest x-ray**

**NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB (MM/DD/YY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*To be completed and signed by a health care provider:*

**Does the student have a history of a positive TB skin test or IGRA blood test**? **□ NO □ YES** [Date: \_\_\_\_\_\_\_\_\_\_\_\_\_]

[If yes]

* 1. Was the student treated for active tuberculosis? □ NO □ YES\* [Date: \_\_\_\_\_\_\_\_ ]
	2. Was the student treated for latent tuberculosis? □ NO (not discussed) □ NO (discussed and declined treatment)

 □ YES [Date Treated: \_\_\_\_\_\_\_ Medication prescribed \_\_\_\_\_\_\_\_\_\_\_\_\_\_]

*\*If student has been treated for active tuberculosis, must provide copies of all screening tests, chest x-rays, and sputum results as well as documentation from an Infectious Disease specialist indicating treatment regimen/dates and that student is no longer infectious.*

**Does student currently have signs or symptoms of active pulmonary tuberculosis disease? □ NO □ YES**

1. [if yes] Proceed with additional evaluation including CXR, sputum, TST/PPD
2. [if no] proceed to TB Screening Tests section below

 **TB SCREENING TESTS- required if any “yes” answers to TB screening questions on medical form.**

**Tuberculin Skin Test/PPD**

Date placed (after May 1, 2024) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date read (48-72 hours later): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Result: \_\_\_\_\_\_\_\_\_\_ mm of induration

Interpretation: □ Negative (no further action required) □ Positive (proceed to chest x-ray below)

**IGRA testing (preferred)** : T-spot or QuantiFERON

Date of test (after May 1, 2024) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Result: □ Negative (no further action required) □ Positive (proceed to chest x-ray below)

 *□ Attach copy of IGRA/PPD results*

 **CHEST X RAY- required if IGRA/TST positive.** Must be done after May 1, 2024.

Date of Chest x ray Result: □ Normal □ Abnormal (requires further evaluation)

*□ Attach copy of chest x-ray report*

**HEALTH CARE PROVIDER** (may NOT be a family member)*:*

*I have reviewed this form and attest that the student is at low to no risk for tuberculosis except as indicated above.*

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Health Services Provided by Newton Wellesley Medical Group | www1.wellesley.edu/healthservice/incomingstudents | 727 Washington St Wellesley, MA 02481 | Office: 781.283.2810 | Fax : 617.831.7234 | Gateway : https://patientgateway.massgeneralbrigham.org