Northwestern Polytechnic University

Clinical Tuberculosis Assessment by Health Care Provider

Clinicians should review and verify the information in the Tuberculosis (TB) Screening Questionnaire (attached). Persons answering YES to any questions in the TB Screening Questionnaire should receive either a Mantoux Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented. **For patients with no history of TB treatment, provider <u>must</u> complete Section I (p. 1-3). For patients with a history of prior or current TB treatment (for active disease or latent infection), provider <u>must</u> complete Section II (p. 4-7).**

History of a positive TST or IGRA? (If yes, provide copy of laboratory report) **Yes** _____ **No** _____

History of BCG vaccination? (If yes, IGRA is preferred) **Yes** _____ **No** _____

History of prior or current TB Treatment? (*If yes, proceed to section II*) **Yes** _____ **No** _____

SECTION I. No History of Prior or Current TB Treatment

1. TB Symptom Check

Does the student have any of the following signs or symptoms of active pulmonary tuberculosis disease?

<u>If yes</u>*, check below* ***and*** *evaluate to exclude active tuberculosis disease including (1) TB test, (2) chest x-ray, and (3) sputum evaluation.* ***GO TO SECTION II.***

- ❑ Cough > 2 weeks
- ❑ Coughing up blood (hemoptysis)
- ❑ Chest pain
- ❑ Loss of appetite
- ❑ Unexplained weight loss
- ❑ Night sweats
- ❑ Fever

<u>If no</u>*, proceed to TB test*

2. TB Test: Tuberculin Skin Test (TST) *<u>or</u>* Interferon Gamma Release Assay (IGRA)

Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write “0”. The TST interpretation should be based on mm of induration as well as risk factors.)*

Date Placed: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: ________ mm of induration *Interpretation: positive____ negative____

***Interpretation guidelines**

≥ 5 mm induration is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

≥ 10 mm is positive for individuals not listed above (California guidelines)

Interferon Gamma Release Assay (IGRA) – ATTACH COPY OF LABORATORY REPORT

Collection date: ____/____/____
M D Y

Method: Quantiferon Gold (QFT)____ T-SPOT____ other_________

Result: negative___ positive___ indeterminate___ borderline___ (T-SPOT only)

If initially indeterminate or borderline, repeat the test and document below:

Collection date: ____/____/____
M D Y

Method: Quantiferon Gold (QFT)____ T-SPOT____ other_________

Result: negative___ positive___ indeterminate___ borderline___ (T-SPOT only)

3. Chest x-ray: (Required if TST or IGRA is positive) – ATTACH COPY OF RADIOLOGY REPORT

Date of chest x-ray: ____/____/____ Interpretation: normal____ abnormal_____
M D Y

- **If chest X-ray is normal, proceed to I (4) "Management of latent TB infection"**
- **If chest X-ray is abnormal consistent with active TB, further TB evaluation is required. Go to Section II, Evaluation for Students with Symptoms or Signs of TB Disease**

4. Management of Latent TB Infection (LTBI)

All students with a positive TST or IGRA who have been fully evaluated and active disease has been ruled out should be treated for LTBI.

___Student accepts treatment (complete section II) ___ Student declines treatment

Provider Attestation

By signing below, the evaluating provider attests that: (1) The student has no symptoms or signs of active TB and (2) the student is not currently infectious for TB.

Provider Name (Please Print)	Provider Signature	Date

Provider Address	Provider Telephone Number

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SECTION II. Evaluation for Students with Symptoms or Signs of TB Disease OR History of Prior or Current Treatment for TB Infection or Disease

Complete evaluation or review applicable to student's TB status

Required evaluation	Symptoms or signs of active TB	Currently on treatment for TB disease	Prior history of TB disease, treatment completed	Currently on treatment for LTBI	Prior history of completed treatment for LTBI	Prior history of positive TB test, no treatment
Provider review of symptoms *(section 1)*	X	X	X	X	X	X
Provider documentation of specific treatment details *(section 2)*		X	X	X	X	
TB testing	X	X		X		
Chest x-ray within 6 months *(section 3)*	X	X	X	X		X
3 sputa for AFB smear, current *(section 4)*	X	X	X			
Prior chest x-ray records *(section 5)*		X	X	X	X	X
Prior sputum AFB smear and culture results *(section 5)*		X	X			
Provider attestation that student has no symptoms or signs of active TB			X	X	X	X
Provider attestation that student is not currently infectious for TB	X	X	X			
Clinician reports TB case to Public Health within 1 working day		X				
Student to bring all original TB diagnostic, microbiology, x-ray and treatment records		X	X			
Student to bring copies of chest and other radiographic images		X	X			

1. TB Symptom Check

Does the student have any of the following signs or symptoms of active pulmonary tuberculosis disease?

*__If yes__, check below **and** evaluate to exclude active tuberculosis disease including (1) TB test, (2) chest x-ray, and (3) sputum evaluation.*

- ❑ Cough >2 weeks
- ❑ Coughing up blood (hemoptysis)
- ❑ Chest pain
- ❑ Loss of appetite
- ❑ Unexplained weight loss
- ❑ Night sweats
- ❑ Fever

2. TB Test: Tuberculin Skin Test (TST) *__or__* Interferon Gamma Release Assay (IGRA)

Tuberculin Skin Test (TST)
(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write “0”. The TST interpretation should be based on mm of induration as well as risk factors.)*

Date Placed: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: ________ mm of induration *Interpretation: positive____ negative____

Interferon Gamma Release Assay (IGRA) – __ATTACH COPY OF LABORATORY REPORT__

Collection date: ____/____/____
M D Y

Method: Quantiferon Gold (QFT)____ T-SPOT____ other_________
Result: negative___ positive___ indeterminate___ borderline___ (T-SPOT only)

If initially indeterminate or borderline, repeat the test and document below:

Collection date: ____/____/____
M D Y

Method: Quantiferon Gold (QFT)____ T-SPOT____ other_________
Result: negative___ positive___ indeterminate___ borderline___ (T-SPOT only)

3. Treatment Details

Treatment for (select one): _____ Active TB Disease or _____ Latent TB Infection

Date Treatment Initiated: ____/____/____
M D Y

Date Treatment Completed (or anticipated completion date): ____/____/____
M D Y

Student's Current Weight: ______ (kg)

Name of Medication	Strength (mg)	Number of Tablets	Frequency (qd, biw, tiw, etc.)	Total Dosage	Route (PO, IV, IM)	Date Started	Date Stopped
Isoniazid							
Rifampin							
Rifamate							
Rifabutin							
Pyrazinamide							
Ethambutol							
Vitamin B-6							

3. Chest and other imaging: (Chest x-ray required within 6 months of start of term) – ATTACH COPY OF RADIOLOGY REPORTS

Date of Imaging (Month/Day/Year)	Anatomical region/image type, e.g., chest x-ray, chest CT	Findings	Interpretation (normal, abnormal)

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4. Microbiology: AFB Smear and Culture – ATTACH COPIES OF LABORATORY RESULTS

Collection date	Specimen type	Smear result	Culture result	Susceptibility results

5. Provider Attestation: By signing below, the evaluating provider attests that: (1) The student has no symptoms or signs of active TB (or if currently under treatment for active TB, is asymptomatic) and (2) the student is not currently infectious for TB.

______________________________ ______________________________ ______________

Provider Name (Please Print) | Provider Signature | Date

______________________________ ______________________________

Provider Address | Provider Telephone Number