People Places

Fostering hope for children and families.

"Our Mission is to foster resilience in children and families so they can thrive."

Tuberculosis Screening

to be completed by a healthcare provider

Name: _____ **DOB:** _____/_____/_____

If YES to **ANY** questions, patient must undergo skin test or chest x-ray.

Please consider the following questions to assess the patient's risk:	**Y**	**N**
1. Does the patient have signs/symptoms of active TB disease?	❑	❑
2. Is the patient a member of a high-risk group?	❑	❑
3. Has the patient ever lived with or been in close contact with anyone who had TB disease?	❑	❑
4. Has the patient ever had a positive HIV test?	❑	❑
5. Has the patient ever had a positive TB test?	❑	❑
6. Has the patient ever used illegal intravenous drugs?	❑	❑
7. Has the patient ever been incarcerated?		
8. Has the patient ever been homeless?	❑	❑
9. Does the patient currently have any of the following: cough, fever, night sweats, or weight loss that is unexplained and has lasted at least three weeks?	❑	❑
10. Was the patient born in, a resident of, or visitor to (spending six weeks or more) countries where TB is endemic?	❑	❑

Based on the available information, the individual can be considered free of tuberculosis in a communicable form. (Circle) Yes No

PLEASE USE THIS SPACE TO DOCUMENT TUBERCULIN SKIN TESTING AND/OR CHEST RADIOGRAPHY (based on assessment of criteria outlined above)

A. Tuberculin Skin Test (to be read in 48 to 72 hours)

Date given: ____ / ____ / ____ Date read: ____ / ____ / ____ Result: _____ mm

(Record actual mm of induration, transverse diameter; if no induration, write "0")

INTERPRETATION: ❑ **NEGATIVE** ❑ **POSITIVE**

B.Chest X-ray (required if PPD is positive or patient is at risk for disease)

Date of X-ray: ____ / ____ / ____ **RESULT:** ❑ **NORMAL** ❑ **ABNORMAL**

Health Care Provider Information *(signature, title, and complete the information below required for validation)*

Provider's Signature: _____ **Date:** _____

Provider Name and Title: (please print) _____

Practice Name: _____

Address: _____

Phone Number/Fax Number: _____

Return This Form To:

□ Staunton/Harrisonburg
Phone: (540) 885-8841
Fax: (540) 886-6379

□ Charlottesville Office
Phone: (434) 979-0335
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