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
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CLEAR FORM