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
520 West Santa Monica Avenue, Dededo, Guam 96929
Phone: (671) 687-4388 / Email: tb.program@dphss.guam.gov

CLEAR FORM

Revised and effective: August 01, 2020