



CHEST X-RAY AND CLASSIFICATION WORKSHEET

For use with TB TI 1991 and the DS-2053

Complete Sections 1 through 5, As Applicable

OMB No. 1405-0113
EXPIRATION DATE: xx/xx/xxxx
ESTIMATED BURDEN: 10 MINUTES
(See Page 2 - Back of Form)

| | |
|-------------------------|-----|
| Name (Last, First, MI.) | Age |
|-------------------------|-----|

| | | |
|-------------------------|-----------------|---------------------|
| Birth Date (mm-dd-yyyy) | Passport Number | Alien (Case) Number |
|-------------------------|-----------------|---------------------|

1. Chest X-Ray Indication (Mark all that apply)

History of Tuberculosis (TB) Disease TB Signs or Symptoms

Contact with Person with TB Adult (With or without any of the other indications)

(If child does not have any of the above, stop here.)

2. Chest X-Ray Findings **Date Chest X-Ray Taken (mm-dd-yyyy)** _____

Normal Findings

Abnormal Findings (Indicate category and finding, checking all that apply, in the table below.)

| <input type="checkbox"/> Can Suggest ACTIVE TB (Need smears) | <input type="checkbox"/> Can Suggest INACTIVE TB (Need smears if symptomatic) | <input type="checkbox"/> OTHER X-Ray Findings |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Infiltrate or consolidation <input type="checkbox"/> Any cavitary lesion <input type="checkbox"/> Nodule or mass with poorly defined margins (such as tuberculoma) <input type="checkbox"/> Pleural effusion* <input type="checkbox"/> Hilar/mediastinal adenopathy with or without atelectasis <input type="checkbox"/> Other (Such as miliary findings) | <input type="checkbox"/> Discrete fibrotic scar or linear opacity (fibrotic scar) <input type="checkbox"/> Discrete nodule(s) without calcification <input type="checkbox"/> Discrete linear opacity (fibrotic scar) with volume loss or retraction <input type="checkbox"/> Other (Such as bronchiectasis) | <input type="checkbox"/> Follow-Up Needed (Mark as "Class B Other") <ul style="list-style-type: none"> <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Cardiac <input type="checkbox"/> Pulmonary, non-TB (e.g., emphysema) <input type="checkbox"/> Other <input type="checkbox"/> No Follow-Up Needed for Pleural thickening, diaphragmatic tenting, calcified pulmonary nodule(s), calcified lymph node(s), calcified lymph nodes with calcified pulmonary nodule(s), or minor musculoskeletal findings |

* If unclear whether pleural fluid or thickening, perform lateral or decubitus chest radiograph, or targeted ultrasound.

Remarks

Radiologist's Signature _____ Date Interpreted (mm-dd-yyyy) _____

3. Sputum Smears

No, Applicant has No Signs or Symptoms of TB and :

- X-Ray Suggests INACTIVE TB, this is a **Class B2/TB**
- OTHER X-Ray Findings Suggest Follow-Up Needed after Arrival, this is **B Other**
- OTHER X-Ray Findings Suggest No Follow-Up Needed, this is **No Class**
- X-Ray Normal, this is **No Class**

Yes, Applicant has (Mark all that apply) : **and Smear Results are:**

| | Positive | Negative | Dates Obtained (mm-dd-yyyy) |
|------------------------------------------------------------------|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> Signs or Symptoms of TB, See Section 1 | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> X-Ray Suggests ACTIVE TB, See Section 2 | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

| | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Sputum Smear Results and X-Ray: At least One Smear Result POSITIVE and <input type="checkbox"/> Any Chest X-Ray Finding (Normal or Abnormal findings), this is Class A/TB | Three Smear Results NEGATIVE and <input type="checkbox"/> X-Ray Normal with <input type="checkbox"/> Signs or Symptoms Resolved, this is No Class <input type="checkbox"/> Signs or Symptoms Suggest Follow-Up Needed after Arrival, this is B Other <input type="checkbox"/> X-Ray Suggests ACTIVE or INACTIVE TB, this is Class B1/TB <input type="checkbox"/> OTHER X-Ray Findings Suggest Follow-Up Needed After Arrival, this is Class B Other |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

4. **No Class** **Class A/TB** **Class B1/TB** **Class B2/TB** **Class B Other**

5. **Follow-Up Needed After Arrival** No Yes If Yes, for Not TB Condition TB Condition

Remarks (If non-TB condition, specify condition below and on DS-2053 form; include additional tests, and therapy used with start and stop dates and any changes. If TB condition, enter information in Part 4 of DS-2053 form.)

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: PRA_BurdenComments@state.gov

CONFIDENTIALITY STATEMENT

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