OMB Control No: 0970-XXXX
Expiration date: XX/XX/XXXX

Supplemental TB Screening

General Information (to be completed by shelter staff)

Child	Last name:	First name:		
	DOB:	A#:	Gender:	
Healthcare Provider or Health Dept.	Name:	Phone number:	Clinic/Practice:	
	Street address:	City/Town:	State:	Date of visit: ____/____/_____
Program	Name of program staff with child:	Program name:		

Medical Info (to be completed by provider's office or health dept.)

PPD/Tuberculin skin test (TST):	**Date applied:** ____ / ____ / _____	**Date read:** ____ / ____ / _____
	Result: _____ mm	**Interpretation**: € Positive € Negative
TB blood test (Interferon-Gamma Release Assay [IGRA]):	**Date drawn:** ____ / ____ / _____	
	Test Type: € QuantiFERON® -TB Gold In-Tube test (QFT-GIT) € T -SPOT® .TB test (T-Spot)	
	Result: € Positive € Negative € Borderline/ Equivocal/ Indeterminate	
Chest x-ray:	**Date:** ____ / ____ / _____	
	Findings: € Normal € Abnormal	
TB Determination:	€ Negative for TB condition € Latent tuberculosis infection (LTBI) € Active TB suspected	

Additional Information