

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:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
TB blood test (Interferon-Gamma Release Assay [IGRA]):	Date drawn: ____/____/____			
	Test Type:		<input type="checkbox"/> QuantiFERON®-TB Gold In-Tube test (QFT-GIT) <input type="checkbox"/> T-SPOT®.TB test (T-Spot)	
	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/ Equivocal/ Indeterminate			
Chest x-ray:	Date: ____/____/____			
	Findings: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			
TB Determination:	<input type="checkbox"/> Negative for TB condition <input type="checkbox"/> Latent tuberculosis infection (LTBI) <input type="checkbox"/> Active TB suspected			

Additional Information

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