OMB Control No: 0970-0466
Expiration date: XX/XX/XXXX

# Supplemental Form: TB Screening
# Unaccompanied Children's Program
# Office of Refugee Resettlement (ORR)

## General Information
(to be completed by program 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 Information
(to be completed by healthcare provider's office or health department)

| | | |
|---|---|---|
| **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 Screening Outcome** | € Negative for TB condition; No further follow up needed | € LTBI € TB rule out (if checked, enter testing info below) |

### Bacteriologic Results

| Collection Date | Specimen Type (e.g., Sputum) | Test Type (e.g., AFB smear) | Result |
|---|---|---|---|
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### Special Requirements for Release

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|---|---|---|---|
| If the child had been AFB smear positive, list the dates of the 3 consecutive negative AFB smears: | #1: | #2: | #3: |
| If the TB culture was positive and the DST was MDR or XDR, list the dates of the 2 subsequent negative cultures: | #1: | #2: | |