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

Special Requirements for Release

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:	