

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:	<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 Screening Outcome	<input type="checkbox"/> Negative for TB condition; No further follow up needed		<input type="checkbox"/> LTBI	<input type="checkbox"/> 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:	

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