

Colgate University Health Services
Required Tuberculosis (TB) Screening

Part II TO BE COMPLETED ONLY IF STUDENT ANSWERED YES TO ANY OF THE 5 QUESTIONS ON PART I SECTION B

Student Name: _____ DOB ____/____/____
(PLEASE PRINT) Last Name First Name M.I.

Medical practitioner:

- Screening must be done within 6 months of the first day of classes.
- A student who has any positive risk factors must be tested for TB infection if there is no written documentation of a previous positive tuberculin skin test (TST) or Interferon gamma release assay (IGRA) (e.g. T-Spot, Quantiferon Gold).
- Previous BCG Immunization does not change TB screening requirements.

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes No

If no, proceed to 2 or 3.

If yes, check below and proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

<input type="checkbox"/> Cough (especially if lasting for 3 weeks or longer) with or without sputum production	<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Coughing up blood (hemoptysis)	<input type="checkbox"/> Unexplained weight loss
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Night sweats
	<input type="checkbox"/> Fever

2. Tuberculin Skin Test (TST)**

<http://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm>

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____ Date Read: ____/____/____
Result: _____ mm of induration **Interpretation:
positive____ negative____

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (QFT-GIT, T-Spot)
Result: negative____ positive____ indeterminate____ borderline____ (T-Spot only)

4. Chest x-ray (Required if TST or IGRA is positive)

Date Obtained: ____/____/____
Result: normal ____ abnormal ____

5. Please indicate any treatment given for positive TB testing: _____

Health care provider (M.D., D.O., P.A., N.P., R.N., school health professional, health official) verifying the above must sign below.

Name (please print): _____

Signature: _____ **Title:** _____ **Date:** _____

Address: _____ **Phone:** _____ **Fax:** _____

