UMASS MEMORIAL MEDICAL CENTER

AMBULATORY SERVICE RECORD FOR STUDENT HEALTH

Name:_____

Date of Birth:_____

Class of:_____

TUBERCULIN SCREENING TEST

Why are you receiving the TST today? □ Routine □ Post Exposure □ Symptomatic

1. **Have you ever had a "POSITIVE" Tuberculin Skin Test? .....□ Yes □ No**
2. **Have you ever had a history of Tuberculosis? .....□ Yes □ No**

***** (If "Yes" to #1 or #2, skip to POSITIVE READINGS section.) *****

_____

_____

3. **Any live vaccines in the last month?**..... □ Yes □ No
   (Students that have received MMR, Varicella, Smallpox or other live vaccines should wait at least 4-6 weeks after the administration of the live virus vaccine unless they are administered on the same day.) *

4. **Do you have any diseases or receiving treatments that decrease your immunity?**...□ Yes □ No
   (Students that are considered immunosupressed because of organ transplant, HIV or other conditions that effect the immune system or are undergoing cancer treatments or have been taking the equivalent of >15mg/day of prednisone for one month or longer may have a decreased reaction or a false- negative reaction to the TST. In these cases an induration of 5mm or more would be considered positive or the provider may want to arrange special timing.) *

5. **Any injection site reaction, skin ulceration or anaphylaxis after TST testing?** .....□ Yes □ No
   Please explain_____
   (TST is contraindicated for persons who have had a severe reaction e.g. necrosis, blistering, anaphylactic shock or ulcerations to a previous TST.) *

6. **Do you currently take any steroidal medications?** .....□ Yes □ No
   (Students taking the equivalent of >15mg /day of prednisone for one month or longer may have a decreased reaction or a false-negative reaction to the TST. In this case an induration of 5mm or greater would be considered positive.) *

(Any "yes" answers must be reviewed with provider prior to TST administration.)

Reviewing Provider Signature _____ □ **M**ay receive □ **M**ay not receive

** Please reference www.cdc.gov/tb for TB Elimination information dated May 2007.*

FOR CLINICAL USE ONLY

TUBERSOL 0.1 ML ID LOT # _____ EXP: _____

Test given in the.....□ Left Forearm □ Right Forearm

Planted by: Name/Title_____ Date_____ Time_____

Green Card _____

READING Read by: Name/Title_____ Date_____ Time _____

RESULTS □ NEG □ POS _____mm induration

Comments_____

□ Did Not Return for Reading □ Name of Physician Notified _____

***** PLEASE TURN TO BACK OF PAGE *****

POSITIVE READINGS / HISTORY OF POSITIVE (ANNUAL SYMPTOM REVIEW)

HX OF BCG □ Yes □ No Date if Immunization_____ Last CXR Date_____
□ Provider Notified of Newly Positive Results
□ Follow-up Appointment Date/ Time/ Provider _____
Sent for chest x-ray _____ date
Pt notified of Chest X-ray Results ___ Copy to provider ___
Staff Signature _____ Date_____

Student to answer the following questions:

Symptoms of TB disease: **Are you experiencing any of the following symptoms?**

Cough, hemoptysis.....□ Yes □ No Fever, chills and/or night sweats.....□ Yes □ No
Shortness of breath.....□ Yes □ No Unexplained weight loss.....□ Yes □ No

Any recent contact with a questionable or known TB positive person?.....□ Yes □ No
If yes, explain_____

□ I do not display any signs/symptoms of TB disease.
□ I do display what may be symptoms of TB disease. I will follow-up with Student Health Services and my health care provider.

I have been provided with information about TB. I have had the opportunity to ask questions and I have had my questions answered to my satisfaction. I understand that a positive TB test means that I have been exposed to TB infection but does not necessarily mean I have active TB disease. I understand that TB is spread from person to person through the air if it becomes active disease. The above symptoms may be signs of active TB disease. If I develop these symptoms I will contact my health care provider.

Student Signature_____ Date_____

Reviewed by: _____ Date _____
New TST conversions must have a Chest x-ray. If positive symptoms, Chest X-ray must be done ASAP (wet read). The Chest X-ray will be reviewed by your provider.

Mask to be worn for any positive symptoms prior to being sent to the X-ray Department.

□ The student has been instructed to keep their mask on until they are in their car and have been advised that we will follow-up with them ASAP with their chest x-ray results.
□ LTBI Form faxed to Infection Control.

STUDENT CONTACT INFORMATION

Name_____
Address_____
_____
Phone #_____