UC San Diego Extension International Programs 2017 TB Form

Tuberculosis (TB) Questionnaire

Required for students in University Credit and Certificate programs.
Please complete and return this form at least 30 days before the program start-date.

Family name of participant _____ First name of participant _____

Date of birth month/ day/ year _____ Student Email Address _____

Please answer the following questions:

- ❍ Have you ever had a positive TB skin or blood test? Yes ☐ No ☐
- ❍ Have you ever had close contact with anyone who was sick with TB? Yes ☐ No ☐
- ❍ Are you from or have you ever lived or traveled in one of the following areas: Mexico, South or Central America, Eastern Europe, Asia, the Middle East, or Africa? Yes ☐ No ☐

If all questions are answered **NO**, you have completed your TB Assessment. Please send the TB Questionnaire to **iphealth@ucsd.edu** or fax it at **+1-858-534-5703**. After you submit the TB Questionnaire, there is nothing more for you to do regarding the TB Assessment.

If any questions are answered **YES**, then **you must also have your health care provider complete the TB Assessment below**, documenting either treatment for TB or negative TB test results. This must be completed and submited to UCSD Extension thirty (30) days before the start of your program. **If TB results are required, the TB test must be taken no more than 1 year from the program start-date.**

Tuberculosis (TB) Assessment

This part of the form must be completed only by a licensed health care provider.
The completed, signed form must be faxed to UC San Diego Extension International Student Services at **001-858-534-5703**.
Or it can be sent to us as a scanned document attached to an email sent to: **iphealth@ucsd.edu.**

RISK FACTORS: (please ask student and check any that apply)

1. Immunosuppressed (HIV/AIDS), organ transplant, or on immunosuppressant medication Yes ☐ No ☐
2. History of abnormal chest x-ray suggestive of TB disease Yes ☐ No ☐
3. Does the student have signs or symptoms of active tuberculosis disease? (Cough more than 3 weeks, chest pain, unexplained weight loss, fevers, night sweats) Yes ☐ No ☐

If no, proceed to 4 or 5. **If yes, proceed with additional evaluation to exclude active TB, including TB skin or blood testing, chest x-ray, and sputum evaluation as indicated, and show results below.**

4. Tuberculin Skin Test (TST)

If there is no history of BCG Vaccine, TST results should be recorded as millimeters (mm) of induration. If no induration, write "0." Five mm is considered positive if there is a history of abnormal chest x-ray, recent exposure to active TB disease, or is immunosuppressed. 10 mm induration is considered positive if coming from a high-risk area or has other high-risk conditions (IV drug use, chronic renal disease, cancer, diabetes, malabsorption or GI bypass).

- ❍ Date TST test was given: _____ month/ day/ year
- ❍ Date TST test was read: _____ month/ day/ year
- ❍ Result: _____ mm induration
- ❍ Interpretation: negative ☐ positive ☐

5. TB Blood Test

(Interferon Gamma Release Assay-IGRA) (The TB blood test may be done instead of TST. Strongly recommended if there is a history of positive TST or BCG vaccination.)

- ❍ Date obtained: _____ month/ day/ year
- ❍ Result: negative ☐ positive ☐ intermediate ☐

6. Chest X-Ray

(required if TST or IGRA is positive)

- ❍ Date of chest x-ray: _____ month/ day/ year
- ❍ Result: normal ☐ abnormal ☐ (including scars, and old granulomatous changes)

If chest x-ray is abnormal, please submit the following results.
Sputum Results (AFB and culture x 3 required if chest x-ray abnormal):

#1 Date_____ AFB_____ Culture_____

#2 Date_____ AFB_____ Culture_____

#3 Date_____ AFB_____ Culture_____

7. Treatment for Latent TB (if applicable):

- ❍ Medication(s) _____
- ❍ Start date: _____ month/ day/ year
- ❍ Completion date: _____ month/ day/ year

Licensed healthcare provider's name (please print in block letters): _____

Healthcare provider's signature: _____ **Date:** _____ month/ day/ year

Healthcare provider's stamp: