TUBERCULOSIS (TB) TESTING RECORD FORM

Name: __________________________________________
CSU ID: ___________________________ Date of Birth: ___________________________

The following must be completed by a healthcare provider:

A TB blood test (IGRA) is preferred for individuals with a history of BCG vaccination.

(**If you have a history of treatment for latent TB infection or treatment for active TB disease, please provide documentation of this treatment. You do not need to have a TB skin test or blood test repeated. Screening will be based on history and symptoms. **)

Tuberculin Skin Test (Mantoux only; no tine tests). TB skin test must be completed within 6 months prior to the start of classes. Please include a copy of test record if available. Results must be recorded in millimeters of induration. If no induration is palpated, please write “0mm”.

   Date placed: ___/___/____     Date read: ___/___/____     Result: ________mm
   Interpretation (based on mm of induration and risk factors) Positive _____ Negative _____

-OR-

TB Blood Test (IGRA). Both T-Spot and QuantiFERON Gold are accepted. TB blood test must be completed within 6 months prior to the start of classes. Please include copy of lab results.

Please check one:  T-Spot.TB _____  QuantiFERON-TB Gold _____

   Date of test: ___/___/____     Result: __________________________________________

Chest x-ray (Chest x-ray is required if TB skin test or TB blood test is newly positive to rule out active TB disease.) Chest x-ray must be completed within 6 months prior to the start of classes. A chest x-ray should not be performed in place of a TB skin test or blood test. If chest x-ray is indicated and performed, please included radiology report.

Result: Normal_____  Abnormal_____  Date of chest x-ray: ___/___/____

Medical Provider or Nurse Signature ___________________________ Address ___________________________

Date _______________ Phone __________________ Fax ____________________