Farmingdale State College
State University of New York

Tuberculosis Screening

Last Name, First, MI: _____ **RAM ID #:** _____

Country of Birth: _____ **Year arrived in US:** _____

SECTION A:

1. **Have you ever had a positive PPD, TB Quantiferon test, or T-SPOT?** ☐ **Yes** ☐ **No**
   (If yes, please provide details in Section C below.)

SECTION B:

1. **Were you born in, or have you lived, worked or visited for more than one month in any of the following: Asia, Africa, South America, Central America or Eastern Europe?** ☐ **Yes** ☐ **No**

If yes, what country? _____ **How long?** _____

2. **Do any of the following conditions or situations apply to you?**

   a) **Do you have a persistent cough? (3 weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss?** ☐ **Yes** ☐ **No**

   b) **Have you ever lived with or been in close contact to a person known or suspected of being sick with TB?** ☐ **Yes** ☐ **No**

   c) **Have you ever lived, worked, or volunteered in any homeless shelter, prison/jail, hospital or drug rehabilitation unit, nursing home or residential healthcare facility?** ☐ **Yes** ☐ **No**

Student Signature _____ **Date** _____

If you answered no to all of the above questions, skip Section C.

If you answered yes to any of the above questions, your medical provider must complete Section C below.

SECTION C:

ATTENTION MEDICAL PROVIDER: If patient answered YES to any of the above questions, a TB test (PPD, T-Spot , or TB QuantiFERON) is REQUIRED. History of BCG vaccination does not exclude patient from this requirement. Test must be done within one calendar year (unless history of positive TB test). If PPD results are 10mm or more, or T-Spot or TB QuantiFERON are positive, a chest x-ray is REQUIRED. For students with history of positive TB test, documentation of dates & results of testing and chest x-ray, as well as treatment information, must be documented below. It is not necessary for these students to repeat TB testing or CXR.

PPD Date Placed: _____ **PPD Date Read:** _____ **Measurement in mm induration:** _____

OR

QuantiFERON-TB Gold or T-Spot Result Date: _____ **QFT-G or T-Spot Result:** ☐ **Positive** ☐ **Negative** ☐ **Equivocal**
Please attach lab report

If PPD results are 10mm or more, or QuantiFERON-TB Gold or T-SPOT results are positive, a chest x-ray is REQUIRED. *(Please attach copy of report.)*

Chest X-Ray Date: _____ **Chest X-Ray Results:** _____

If negative CXR and positive PPD/Lab Result, did the patient complete a course of INH or other TB Treatment? ☐ **Yes** ☐ **No**

If yes, name & dose of medication: _____

Date Range of Treatment: _____ **How many months did student take medication? (# of months)** _____

PROVIDER INFORMATION REQUIRED

Signature/Stamp of medical provider _____ **Phone number of practice** _____ **Date** _____