THE CATHOLIC UNIVERSITY OF AMERICA | Conway School of Nursing

Washington, D.C. 20064
202.319.5400

TB TEST FORM

Tuberculin screening and testing is an annual requirement for all students and some clinical partners may require it at the start of each new clinical rotation. Additionally, students **MUST** undergo Tuberculin skin test (TST) **OR** have one Interferon Gamma Release Assay Test (IGRA) if **THEY** answered yes to 1 or more risk questions on the *TB Risk Assessment Form,* at any point during the year.

A. Two step – Tuberculin Test (PPD)

PPD #1: Date placed: _____ Date read: _____ Results: _____ mm □ Positive □ Negative

A PPD/TST of ≥ 5 mm induration is considered positive for immunocompromised students
A PPD/TST of ≥ 10 mm induration is considered positive for immigrants from high prevalence countries.
A PPD/TST of ≥ 15 mm induration is considered positive for students with no risk factors.

Second PPD test must be completed at least 1-3 weeks after the first PPD test result.

PPD #2: Date placed: _____ Date read: _____ Results: _____ mm □ Positive □ Negative

A PPD/TST of ≥ 5 mm induration is considered positive for immunocompromised students
A PPD/TST of ≥ 10 mm induration is considered positive for immigrants from high prevalence countries.
A PPD/TST of ≥ 15 mm induration is considered positive for students with no risk factors.

Student Name: _____

Student Signature: _____

Health Care Provider (PCP) Name (Print): _____

HCP Signature: _____

HCP Address: _____

_____

Telephone Number: _____

B. IGRA (preferred for students who have received BCG vaccine)

Date performed: _____ Result*: _____ □ Positive □ Negative

□ QuantiFERON Gold or □ T-Spot IGRA = QuantiFERON Gold or T-Spot.

* Indeterminate or borderline results are not acceptable. Repeat test or administer two-step TST.

MUST BE SUBMITTED prior to beginning of nursing rotations
DO NOT SUBMIT TO CSON, SUBMIT TO the CSON Compliance platform

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****Attach copy of lab report****

Student Name: _____

Student Signature: _____

Health Care Provider Name (print): _____

HCP Signature: _____

HCP Address: _____

_____

Telephone Number: _____

C. Nursing Students Who Have Tested POSITIVE to PPD Skin Test or IGRA

If you have a positive PPD or IGRA, you must have a health care provider certify that you have had a negative Chest X-ray within the past 5 years.

Date of Chest X-ray: _____ Chest X-ray results: _____

Student Name: _____

Student Signature: _____

Health Care Provider (HCP) Name (Print): _____

HCP Signature: _____

HCP Address: _____

_____

Telephone Number: _____

D. Treatment for TB disease or Latent TB Infection

□ Completed □ Ongoing Dates of treatment regimen: _____ to _____ (attach documentation)

Health Care Provider Name (print): _____

HCP Signature: _____

Date: _____ Phone: _____

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Tuberculosis Symptom Questionnaire

Name: _____ Student ID: _____

DOB: _____/_____/_____ **Phone#**_____

Section 1. Check Yes/No for each symptom. If Yes provide duration symptom(s) have been present

SYMPTOM	YES	NO	DURATION	COMMENTS
Cough >3 Weeks				
Bloody Sputum/Phlegm				
Pain in Chest				
Weakness or Fatigue				
No Appetite				
Weight Loss				
Fever				
Chills				
Night Sweats				

Have you ever been treated for Active or Latent Tuberculosis? ☐Yes ☐No If yes, please provide the treatment start and end date. Start Date _____/_____/_____ **End Date** _____/_____/_____

Section 2. Check Yes/No for each question.

Have you had close contact with someone who has been diagnosed with infectious TB since your last TB Screening? ☐ No ☐ Yes

Have you had temporary of permanent residence of >1 month in country with a high incidence of TB? Includes any country other than the United States, Canada, Australia, New Zealand, Western Europe, Northern Europe? ☐ No ☐ Yes If Yes where? _____

Current or planned immunosuppression? Including HIV infection, organ transplant recipient, treatment with TNF-alpha antagonist, chronic steroid use (>15mg/day for >1month) or any other immunosuppressive medications ☐ No ☐ Yes

Student **Signature**_____ **Date**____/_____/_____