Framingham State University Tuberculosis (TB) Health Care Provider Form

Directions to Student:
Step 1: Log in to the Student Health Portal and complete the ONLINE TB Screening Questionnaire

Step 2: This TB Medical Provider form is to be filled out by *a health care provider* ONLY if you were directed to do so after completion of the ONLINE TB Questionnaire

Student Name: _____ Date of Birth (Month/Day/Year): _____

Directions to the health care provider: This form is ONLY required for students who have indicated one of the following risk factors for latent TB infection:

___ Previously positive TB screening test and/or diagnosis of TB Infection (latent TB) or TB disease

___ Born in or lived in any of the following locations: Africa, Asia (except Japan), Central America (except Costa Rica), South America (except Chile), Mexico, Eastern Europe, Russia, the Caribbean (except Puerto Rico, Barbados, Bermuda or Aruba) or the Middle East (except Israel)

___ Close contact with someone who was diagnosed with TB

___ Immunosuppression (current or planned), HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, etc.) or treated with steroids (equivalent to prednisone 15 mg/day or more for 1 month or more)

STEP 1 - TUBERCULOSIS TESTING: Must be performed within 6 months of semester start date
IGRA (QuantiFERON or T-SPOT) preferred but TST is also acceptable
***** If this test has been previously done and resulted positive, skip to Step 2 *****

Date of IGRA (QuantiFERON Gold or T-Spot) _/___/___ Positive/Negative *Attach laboratory report (Required)

OR

Date of Tuberculin Skin Test Date planted ___/___/___ Date Read __/___/___ _____ mm induration

STEP 2 - IF ANY POSITIVE IGRA or TST (current or past), CHEST X-RAY & CLINICAL EVALUATION IS REQUIRED:
(further TB testing is NOT required and will not be accepted)

Date of POSITIVE Test ___/___/___ Treatment? YES/NO

If treated, indicate drug name/dosages/dates and date of completion: _____

_____

Chest X-Ray: if treated, X-Ray must be performed at or after time of diagnosis; if untreated, X-Ray must be updated within 2 years of semester start date
Date of Chest X-Ray: __/__/__ Normal/Abnormal *Attach Chest X-Ray Report (Required)

Symptom Screen: *REQUIRED for students with current positive TB test or untreated past positive; must be screened within the past year if untreated*

	YES	NO		YES	NO
Prolonged Cough (3 or more weeks)			Hemoptysis		
Fever			Fatigue		
Night Sweats			Loss of Appetite		
Weight Loss			Chest Pain		

HEALTH CARE PROVIDER

Name: _____ Signature: _____ Date: _____

Office address: _____ Phone: _____