**DALLAS COUNTY**
HEALTH AND HUMAN SERVICES
**Tuberculosis Elimination Division**

**Philip Huang, MD, MPH**
**Director**

# Tuberculosis Screening Form

**Please complete the entire form.**
The information provided will assist the healthcare worker in interpreting the results of standard tuberculosis (TB) tests to determine possible TB infection**. Print clearly using black or blue ink.**

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Last Name:_____ First Name: _____ Birth Date:_____ SS#: _____

Address:_____ Race:_____ Ethnicity:_____ Sex:___

City/State/Zip:_____ Telephone:_____

Country or Origin (Birth Country): _____ Month/Year Arrived in United States: _____

## Emergency Contact Information

Name**:** _____ Relationship: _____

Phone Number: _____ Alternate Phone: _____

**TB Symptoms (check all that apply):** □ Fever □ Cough □ Night Sweats □ Weight Loss □ Other: _____

Previous TB Test Result: _____ Year: _____

Treatment for TB: □ No □ Yes Dates: _____ Medication: Completed? □ Yes □ No

**Check any that apply to your history:**
□ Travel to country with high TB risk □ Lived/worked in shelter, jail, or long-term care
□ Healthcare worker □ Injected drugs □ Contact with TB case

**Medical conditions (check all that apply):**
□ HIV □ Diabetes □ Cancer □ Kidney disease □ Organ transplant □ Taking immune-suppressing meds

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**Consent for TB Testing:**
By signing below, I give permission to the Dallas County Tuberculosis Elimination Staff to Perform diagnostic TB tests, such as skin or blood tests and render definitive or prophylactic treatment as deemed necessary. I understand my information will be kept private.

**If the patient is a minor (under 18 years old):**
I am the parent or legal guardian of the minor listed above and give permission for TB testing and treatment as described above.

Patient/Guardian Name (Print): _____

Signature: _____ Date: _____

**Submit by Email**

# Office Use Only

## TB Skin Testing

For persons at low risk for TB, for whom tuberculin testing is not generally indicated, tuberculin skin tests are **positive at 15mm of induration or larger**: ☐ No risk identified ☐ Refused Testing

**Reminder** If/When testing is repeated, the same type of test (TST or IGRA) should be used.

Test/Date:_____ Administered by: _____

Test Location: ☐ Left Arm ☐ Right Arm ☐ Other: _____

Manufacturer:_____ Lot #:_____ Expiration Date:_____

Read Date:_____ Read by:_____Reading:_____mm

## Interferon Gamma Release Assay (IGRA)

Test/Date: _____ Administered by: _____

Test: QFT-GIT_____ T-Spot_____ other_____

Result: negative_____ positive_____ indeterminate_____ borderline_____ (T-Spot only)

## Chest X-Rays

Chest X-ray/Date:_____ Results:_____

Health-Care Provider: _____

Interpreter**:** _____

## Progress Notes