Central Montana
Health District
Public Health Programs

Tuberculosis Screening Tool

_________________________________ Last name, first name, middle initial

____/____/______ Date form completed

____/____/_____ Date of birth

(______)____________ Phone number

Healthcare Provider Name: ____________________

HCP Phone Number: _____________________

Baseline TB screening includes two components:

(1) Assessing for current symptoms of active TB disease

and

(2) Testing for the presence of infection with *Mycobacterium tuberculosis* by administering a single TB test.

Symptoms of active TB disease (circle all that are present)

Coughing (>3 weeks)	Chest pain	Fatigue
Night sweats	Coughing up blood	
Weight loss/poor appetite	Fever/chills	

Note: If TB symptoms are present, promptly refer client to their provider of record as named above for follow-up.

I believe I understand the risks and benefits of tuberculin skin testing, have had the opportunity to ask questions, and request that this testing be administered to me or the person named below for whom I am authorized to make this request. I understand that documentation of this test may be placed in the state-wide immunization registry and give Central Montana Health District consent to bill Medicare/Medicaid or other insurances/entities as named for services rendered. By signing this form, I confirm that I have been given/offered a copy of the CMHD Notice of Privacy Practices and have had my questions answered to my satisfaction.

Client Signature or Authorized Representative:

_________________________________ Printed Name

_________________________________ Signature

Date: __________________

Tuberculin skin testing (TST)

Administration		
Name of person administering test		
Date and time administered		
Location (circle)	L forearm R forearm Other:____	
Tuberculin manufacturer		
Tuberculin expiration date and lot #		
Signature of person who administered test		
Results	**Results** (read 48-72 hours after placement of First Step)	
Date and time read:		
Number of mm of induration: (across forearm)	____mm	
Interpretation of reading* (circle)	Positive** Negative **Referred to Healthcare Provider for follow-up: _______ (RN initial)	
Reader's signature		

*Consult CMHD Standing Orders for Administering/Interpreting Tuberculin Skin Tests
** Refer HCW to their provider of record as named above for follow-up.

Adapted by the Central Montana Health District from materials provided by the CDC MMWR, 12/30/2005, Vol 54 No RR-17, Guidelines for Preventing the transmission of mycobacterium tuberculosis in Health-Care Settings, 2005, ; the Minnesota Department of Health Tuberculosis Prevention and Control Program; the Global Tuberculosis Institute; Francis J. Curry National Tuberculosis Center