Tuberculosis (TB) Health Assessment Form
University of California, Santa Barbara

Name of Student _____

Date of Birth *(month/day/year)* _____

Perm# _____

This student is **REQUIRED to complete tuberculosis testing** prior to enrolling in classes.
The form must be **completed and signed by a licensed health care provider** and the test results attached**.**

History Questions (ALL 6 QUESTIONS MUST BE ANSWERED)	Yes	No	Comments
Has the student ever had a positive IGRA test (Quantiferon or T-Spot)?			If yes, order chest x-ray & symptom screen.
Has the student ever had a positive TB skin test?			If yes, order an IGRA.
Has the student ever been treated for latent tuberculosis infection? Medication_____ Start date_____ End date _____			If yes, please attach documentation if available. No further testing required at this time.
Has the student ever been treated for active TB disease?			If yes, must attach summary of treatment letter and most recent chest x-ray report. No further testing required at this time.
Has the student ever had close contact with persons known or suspected to have active TB disease?			Date of last contact: _____
Does the student have signs/symptoms of active TB disease? (Cough greater than 3 weeks, hemoptysis, unexplained weight loss, fevers, night sweats)			If yes, evaluate as clinically appropriate.

TESTING – ALL TESTING MUST HAVE BEEN DONE ON OR AFTER SEPTEMBER 1, 2016

1. Tuberculosis Test
Choose *one (a. or b.)* of the following options:

a. TB Blood Test (IGRA)
Recommended if history of BCG vaccine; if not available, may do a TST or chest xray.
Date Obtained: _____
Result: □ Negative □ Positive (**If Positive, proceed to #2**)
□ Indeterminate (**If Indeterminate, repeat test or proceed to #2**)

b. Tuberculin Skin Test (TST)
≥5 mm is positive if:
- Recent close contact with someone with active infectious TB disease
- Immunosuppressed (splenectomy, HIV, chemotherapy, transplant patient)
- History of an abnormal chest x-ray suggestive of TB

Otherwise ≥10mm is positive
Date placed:_____ **Date read**:_____
Result:_____ mm induration. (If no induration, write Ø)
Interpretation: □ Negative □ Positive **(If Positive, proceed to #2)**

2. Chest X-ray (***REQUIRED in last 12 months if current or past TST or IGRA is positive***) ***Must attach written radiology report**
Date of chest x-ray: _____
Result: □ Normal
□ Abnormal - r/o active TB must have Sputum Induction - proceed to #3
□ Abnormal - other – Specify: _____

3. Sputum Results (3 negative AFB smears and cultures are **required** if the chest x-ray is read as concerning for TB)
#1 Date_____AFB_____Culture_____
#2 Date_____AFB_____Culture_____
#3 Date_____AFB_____Culture_____

Submit this form by uploading it on Gateway: https://studenthealthoc.sa.ucsb.edu

or by emailing it to SHSEntranceImmunizations@sa.ucsb.edu or FAX (805) 893-3593

For questions, see our FAQ Page at http://studenthealth.sa.ucsb.edu/medical-services/immunization-information/university-immunization-requirements/tuberculosis-(tb)-screening-requirement or Phone (805) 893-2525

I certify the student is free of infectious tuberculosis.

_____ _____
Signature of Licensed Healthcare Provider **Date**

_____ _____
Printed Name of Licensed Healthcare Provider **MD/DO/NP/PA/RN**

Office Stamp or Address & Phone