TUBERCULOSIS (TB) TESTING FORM

Name: ____________________________
CSU ID: __________________________ Date of Birth: __________________________

The following must be completed by a physician’s office:

(***If you have a history of treatment for latent TB infection or treatment for active TB disease, you must provide documentation of this treatment. You do not need to have a TB skin test or blood test repeated. Screening will be based on symptoms and, in some situations, a chest x-ray may be required***)

Tuberculin Skin Test (Mantoux only; no tine tests). TB skin test must be completed within 6 months prior to the start of classes. Please include a copy of test record if available. Results must be recorded in millimeters of induration. If no induration, please write “0mm”.

Date given: ___/___/____  Date read: ___/___/____  Result: _________mm

Interpretation (based on mm of induration and risk factors) Positive ______ Negative ______

-OR-

TB Blood Test (IGRA). Both T-Spot and QuantiFERON Gold are accepted. TB blood test must be completed within 6 months prior to the start of classes. Please include copy of lab results. Please check one:  T-spot _____  QuantiFERON-TB Gold _____

Date of test: ___/___/____  Result: ________________________________

Chest x-ray  (Chest x-ray is required if TB skin test or TB blood test is positive in order to rule out active TB disease) Chest x-ray must be completed within 6 months prior to the start of classes. Please include chest x-ray report.

Result: Normal_____ Abnormal_____  Date of chest x-ray: ___/___/____

________________________________________________________________________

Physician or Nurse Signature  Address

________________________________________________________________________

Date  Phone  Fax

Rev 7/2017