

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ DOB \_\_\_\_\_

Tuberculosis is an infectious bacterial disease, screening is required for all incoming students. Please use the flowchart below to see if you are required to provide further TB information. The requirement for laboratory testing, chest x-ray and a medical provider evaluation is dependent on your health history and risk factors.

1. Have you ever had a test that indicated you were infected (tested positive) for tuberculosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you been treated for tuberculosis (latent, active, or infectious tuberculosis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

NO (to both questions)

YES (to one or both questions)

3. Were you born in, traveled to, or lived for more than one month in a country or territory with an elevated rate of tuberculosis? <i>Generally, these are all countries and territories outside of the United States, Canada, Australia, New Zealand, Western Europe and Northern Europe. See next page for a list of countries with an elevated rate of tuberculosis.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have immunosuppression, current or planned? <i>HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids equivalent to prednisone ≥ 15mg/day for ≥ 1 month, or other immunosuppressive medication.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. To the best of your knowledge, have you had close contact with anyone who was sick with tuberculosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been a resident or worked in a homeless shelter or correctional facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Need:**

1. Send all records related to your testing and/or treatment.
2. See your medical provider to complete and upload the *Medical Provider TB Evaluation Form* on page 3.
3. Obtain chest x-ray and upload the report of the result. Documentation must be in English. \*Must be dated within last 6 months.

NO (to all questions)

YES (to one or more questions)

**Need:**

1. Upload this form.

**Need:**

Have an Interferon-Gamma Release Assay (IGRA)\* blood test for tuberculosis and upload the result. \*Must be dated within last 6 months.

NEGATIVE  
IGRA RESULT

POSITIVE  
IGRA RESULT

**Need:**

1. Upload IGRA results along with this form.

**Need: \*Must be dated within last 6 months.**

1. Upload IGRA results along with this form.
2. See your medical provider to complete and upload the *Medical Provider TB Evaluation* on page 3.
3. Obtain chest x-ray and upload the report of the result. Documentation must be in English.

\* If the Interferon-Gamma Release Assay (IGRA) blood test or chest x-ray is unavailable to you at your current location, you must visit Student Health Services within 1 week after arriving on campus. Testing will be ordered and completed at your expense. Student Health Services does not bill insurance or submit insurance claims on your behalf.

<b>A</b>	Djibouti	Libya	Russian Federation
Afghanistan	Dominica	Lithuania	Rwanda
Algeria	Dominican Republic		
Angola	<b>E</b>	<b>M</b>	<b>S</b>
Argentina	Ecuador	Madagascar	Sao Tome and Principe
Armenia	El Salvador	Malawi	Senegal
Azerbaijan	Equatorial Guinea	Malaysia	Sierra Leone
	Eritrea	Maldives	Singapore
	Eswatini	Mali	Solomon Islands
	Ethiopia	Malta	Somalia
<b>B</b>		Marshall Islands	South Africa
Bangladesh	<b>F</b>	Mauritania	South Sudan
Belarus	Fiji	Mexico	Sri Lanka
Belize	French Polynesia	Micronesia	Sudan
Benin		(Federated States of)	Suriname
Bhutan	<b>G</b>	Moldova	
Bolivia (Plurinational State of)	Gabon	Mongolia	
Bosnia and Herzegovina	Gambia	Morocco	
Botswana	Georgia	Mozambique	<b>T</b>
Brazil	Ghana	Myanmar	Taiwan
Brunei Darussalam	Greenland		Tajikistan
Burkina Faso	Guam	<b>N</b>	Tanzania
Burundi	Guatemala	Namibia	Thailand
	Guinea	Nauru	Timor-Leste
	Guinea-Bissau	Nepal	Togo
	Guyana	Nicaragua	Tunisia
<b>C</b>		Niger	Turkmenistan
Cabo Verde	<b>H</b>	Nigeria	Tuvalu
Cambodia	Haiti	Northern Mariana Islands	
Cameroon	Honduras		<b>U</b>
Central African Republic		<b>P</b>	Uganda
Chad	<b>I</b>	Pakistan	Ukraine
China	India	Palau	Uruguay
China, Hong Kong SAR	Indonesia	Panama	Uzbekistan
China, Macao SAR	Iraq	Papua New Guinea	
Colombia	<b>K</b>	Paraguay	<b>V</b>
Comoros	Kazakhstan	Peru	Vanuatu
Congo	Kenya	Philippines	Venezuela (Bolivarian Republic of)
Côte d'Ivoire	Kiribati		Vietnam
	Kyrgyz Republic	<b>Q</b>	
		Qatar	<b>Y</b>
<b>D</b>	<b>L</b>		Yemen
Democratic People's Republic of Korea	Lao People's Democratic Republic	<b>R</b>	
Democratic Republic of the Congo	Latvia	Republic of Korea (South Korea)	<b>Z</b>
	Lesotho	Romania	Zambia
	Liberia		Zimbabwe



**STUDENT WELLNESS SERVICES**  
*MEDICAL PROVIDER TB EVALUATION FORM*

Please print and have your medical provider complete this form **ONLY** if you have a **POSITIVE IGRA RESULT** or were otherwise prompted to complete this form when completing the Tuberculosis (TB) Questionnaire.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ DOB \_\_\_\_\_

1. Does patient recently or currently exhibit any symptoms of active pulmonary tuberculosis?

- |             |                              |                             |               |                              |                             |
|-------------|------------------------------|-----------------------------|---------------|------------------------------|-----------------------------|
| Cough       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Night sweats  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest pain  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fever         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hemoptysis  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Chills        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Weight loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other symptom | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

\_\_\_\_\_  
\_\_\_\_\_

2. Please list the date(s) and results of previous tuberculosis testing.

\_\_\_\_\_  
\_\_\_\_\_

3. Please list the date(s) and results of previous tuberculosis treatment.

\_\_\_\_\_  
\_\_\_\_\_

4. Please describe any recommendation or plans for further testing or treatment.

\_\_\_\_\_  
\_\_\_\_\_

5. Please add any additional relevant information. Records may be given to student to upload securely to Caltech Student Wellness Services.

\_\_\_\_\_  
\_\_\_\_\_

**CERTIFICATION OF HEALTHCARE PROVIDER**

Signature of Healthcare Provider:

Healthcare Provider Name:

Date:

Address:

Phone Number: