

Last Name _____ First Name _____ DOB _____

Tuberculosis is an infectious bacterial disease, screening is required for all incoming students. Please use the flow chart 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 and complete the <i>Medical Provider TB Evaluation Form</i>
3. Obtain chest x-ray and upload the report of the result. Documentation must be in English.

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.

NEGATIVE
IGRA RESULT

POSITIVE
IGRA RESULT

Need:
1. Upload IGRA results

Need:
1. Upload IGRA results
2. See your medical provider and complete the <i>Medical Provider TB Evaluation Form</i>
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 the next business day 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.

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



STUDENT WELLNESS SERVICES
MEDICAL PROVIDER TB EVALUATION FORM

Last Name _____ First Name _____ DOB _____

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

Cough Yes No

Night sweats Yes No

Chest pain Yes No

Fever Yes No

Hemoptysis Yes No

Chills Yes No

Weight loss Yes No

Other symptom Yes 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: