

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.

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		Nicaragua	Turkmenistan
Cambodia	H	Niger	Tuvalu
Cameroon	Haiti	Nigeria	
Cape Verde	Honduras	Northern Mariana Islands	U
Central African Republic			Uganda
Chad	I	P	Ukraine
China	India	Pakistan	Uruguay
China, Hong Kong SAR	Indonesia	Palau	Uzbekistan
China, Macao SAR	Iraq	Panama Papua New Guinea	
Colombia		Paraguay	V
Comoros	K	Peru	Vanuatu
Congo	Kazakhstan	Philippines	Venezuela (Bolivarian Republic of)
Côte d'Ivoire	Kenya	Portugal	Viet Nam
	Kiribati		Y
D	Korea (Republic of)	Q	Yemen
Democratic People's Republic of Korea	Kuwait	Qatar	
Democratic Republic of the Congo	Kyrgyzstan		Z
		R	Zambia
	L	Romania	Zimbabwe
	Lao People's Democratic Republic	Russian Federation	
	Latvia	Rwanda	
	Lesotho		
	Liberia		



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: