Annual Tuberculosis Screening Document

NAME:	DOB:	DATE:
EMAIL ADDRESS:	PHONE:	EMPLOYMENT TYPE:
DUTY STATION/SHIP:		

This form must be used to document the annual tuberculosis screening required by NOAA Policy 1008 of all persons seeking medical clearance by NOAA Health Services. This form has three sections to include Section A: Tuberculosis History Screening, Section B: Tuberculosis Testing, and Section C: Latent Tuberculosis Screening and Recommendations. **Section A is required to be filled out by any individual seeking clearance**. Section B and Section C are only required if the healthcare professional performing the screening deems them necessary. **(If sections B and C have been completed and submitted to NOAA previously, no need to resend this documentation unless new risk is disclosed).**

Section A: Tuberculosis History Screening **To be completed by the individual**			Yes	No
1		Do you have a history of a positive TB test, or a history of having TB?	☐	☐
2		Have you ever taken medication for the treatment of TB? If so, when did you complete treatment? _____	☐	☐
3		Were you born in a country with an elevated risk of TB? (listed below)	☐	☐
4		Have you recently traveled to a country with an elevated risk for TB?	☐	☐
5		At any time have you been exposed to someone diagnosed or suspected of having active TB?	☐	☐
6		Do you have a medical condition or undergoing treatment that affects the immune system?	☐	☐
7		Have you ever received an immunization for tuberculosis, commonly known as BCG?	☐	☐
8		Have you had any of the following in the past year?	Yes	No
	a.	Unexplained Cough?	☐	☐
	b.	Coughing up Blood?	☐	☐
	c.	Unexplained Weight Loss?	☐	☐
	d.	Unexplained Fatigue?	☐	☐
	e.	Unexplained Fever?	☐	☐
	f.	Unexplained Night Sweats?	☐	☐

Countries with an Elevated Risk of Tuberculosis

As per World Health Organization's list of high burden countries 2019-2025

Angola, Bangladesh, Brazil, China, Democratic People's Republic of Korea, Democratic Republic of the Congo, Ethiopia, India, Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Pakistan, Philippines, South Africa, Thailand, Uganda, United Republic of Tanzania, Vietnam, Republic of the Congo, Gabon, Lesotho, Liberia, Mongolia, Namibia, Papua, New Guinea, Sierra Leone, Zambia

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize my primary care doctor, treating hospital, or prior clinics to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.18 U.S. Code § 1001

SIGNATURE:	DATE:

Provider's recommendation following tuberculosis screening

If the individual is found to be of minimal risk, no further action is needed. If further testing is recommended by the healthcare professional, continue on to section B.

PROVIDER'S COMMENTS:		
Tuberculosis risk assessment, based on above responses	☐ **MINIMAL**	☐ **INCREASED**
Recommend Latent Tuberculosis Infection (LTBI) Testing	☐ **NO**	☐ **YES**
PROVIDER'S CONTACT INFORMATION		PROVIDER'S PHONE:
PROVIDER'S NAME AND SIGNATURE		DATE:

STOP. Providers, if answers were 'increased' or 'yes' in the providers recommendation section above, continue on to section B and C (or continue regardless of these answers if this is part of a new hire physical exam).

Section B: Tuberculosis Testing

To be completed by the healthcare professional performing the tuberculosis testing if indicated.

TST TEST RESULTS		QUANTIFERON GOLD OR T-SPOT RESULTS	
DATE GIVEN Lot #: Expiration: Manufacturer:	DATE READ	DATE TEST OBTAINED	TEST TYPE ____ QFT-G ____ T-SPOT
RESULT _____ MM INDURATION	INTERPRETATION _____ POSITIVE _____ NEGATIVE	TEST RESULT ____ POSITIVE ____ NEGATIVE ____ INTERMEDIATE/BORDERLINE	
PROVIDER SIGNATURE AND DATE		PROVIDER SIGNATURE AND DATE	

Section C: Latent Tuberculosis Screening and Recommendation

To be completed by a healthcare provider.

NOAA policy requires that all persons with a recent or remote positive test for exposure to the tuberculosis bacteria must obtain an annual physical examination by a licensed medical provider (physician, nurse practitioner, or physician assistant) to determine if latent TB infection or active disease is present, and if persons with latent infection are at high risk for developing active disease.

I have read the TST/Quant-G test or examined this patient and made the following determination:

☐	**Negative TST or Quant-G test** no examination required.
☐	**Latent TB** infection with **low risk** of developing active disease. No treatment intervention recommended at this time.
☐	**Latent TB** infection with **high risk** of developing active disease. Prophylactic Medication(s) Prescribed: _____ Date Prophylactic Medication began _____ Date Prophylactic Medication will be completed _____
☐	**Active Tuberculosis**.

PROVIDER COMMENTS:	
PROVIDER CONTACT INFORMATION:	**PROVIDER PHONE:** **EXAMINATION DATE:**
PROVIDER NAME AND TITLE:	**PROVIDER SIGNATURE:**