ADDITIONAL TB TESTING

GOUCHER college

STUDENT HEALTH CENTER

To be completed by a physician, physician's assistant, or nurse practitioner no more than six months prior to admission.

1021 Dulaney Valley Rd., Baltimore, MD 21204
Phone: (410)337-6050
Fax: (410)337-6051
Upload completed & signed form to:
https://goucher.medicatconnect.com

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name & Pronouns:_____

Date of Birth: _____ Student ID Number: _____

Screening Questions

Have you ever had a TB test that was positive or have you been diagnosed with or treated for TB? Yes ☐ No ☐

Have you had close contact or are you living with a person with active TB disease? Yes ☐ No ☐

Have you been a resident and/or employee of a high-risk congregate setting (e.g. correctional facility, long-term care facility, homeless shelter)? Yes ☐ No ☐

Have you been a volunteer or healthcare worker who served patients who are at increased risk for active TB disease? Yes ☐ No ☐

Were you born in one of the countries or territories that have a high incidence of active TB disease? Yes ☐ No ☐

Have you resided in or traveled to one or more of the countries or territories that have a high incidence of active TB disease for a period of one month or longer? Yes ☐ No ☐ Full list of countries: https://goucher.medicatconnect.com/form/ACHA_List_.pdf

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS ABOVE, TESTING IS REQUIRED.
A HEALTHCARE PROVIDER MUST COMPLETE THE REST OF THIS FORM.

History of BCG vaccination? Yes ☐ No ☐ (If yes, the Interferon-Gamma Release Assay - IGRA - is the preferred test)

Either a PPD skin test or IGRA labwork must be performed within six (6) months of starting at Goucher College.

PPD (Purified Protein Derivative TB) Skin Test

Date Placed: _____ Date Read: _____

Results: Positive ☐ Negative ☐ _____mm

If positive, you must complete IGRA or attach radiology report/interpretation of a chest x-ray. If negative, no further action is needed.

IGRA (Quantiferon Gold or T-SPOT) Test:

Date: _____

Results: Positive ☐ Negative ☐

If positive, you must have a chest x-ray and attach radiology report/interpretation. If negative, no further action is needed.

I hereby certify that I have reviewed the results of the patient's TB testing and they show no evidence of active TB infection at this time:

_____

Signature (MD/DO/NP/PA/RN)

Date: _____

Printed Name: _____

Office Address: _____

_____

Office Phone Number: _____