Tuberculosis Risk Assessment
Medical Provider Follow-up Form

NAME: Last_____ **First**_____ **Date of Birth**_____/_____/_____

Student:

Please indicate which of these three questions you answered "yes" to on the electronic risk assessment:

- ❑ Have you had close contact with anyone who was sick with tuberculosis (TB)?
- ❑ Were you born in a country other than Australia, Canada, New Zealand, the U.S. or Western Europe?
- ❑ Have you traveled or lived for more than a month in a country other than Australia, Canada, New Zealand, the U.S. or Western Europe?

Health Care Provider:

Please use this form to document the required Tuberculosis testing and follow-up you have provided for this student:

Based on the information provided by the student, a PPD test (Mantoux) within the previous 12 months is required.
Please administer and/or record PPD test results below:

Date Planted:_____	Date Read:_____	Results:_____m of Induration

If PPD is negative, **STOP HERE**.

If PPD is positive, or there is a history of a positive PPD without treatment*, Interferon Gamma Release Assay (IGRA or Tspot) is required.

IGRA or Tspot Date (mm/dd/yyyy):_____	Result: Positive_____ or Negative_____

If IGRA is negative, **STOP HERE**.

Chest X-ray required if IGRA or Tspot is positive

Chest X-Ray Date (mm/dd/yyyy):_____	Results: Normal_____ or Abnormal_____

If Chest X-Ray is normal, **STOP HERE**.

Copy of Chest X-Ray Report is required if result is abnormal.

'* If you have been treated for a positive PPD or IGRA/Tspot, no further testing is required. Please document below, including dates of treatment.

_____

_____

_____

Name of Health Care Provider (please print):_____

Signature of Health Care Provider:_____

Signature ***Date***