Tuberculosis (TB) Screening and Testing Record

Note: This form is designed for clinical record-keeping and printing. Please fill out all text fields manually.

1. Patient Information

Patient Full Name:		Date of Birth (MM/DD/YYYY):	
Medical Record / ID Number:		Phone Number:	
Street Address:			

2. TB Symptom Screen

Please type "Yes" or "No" and provide details if applicable for each symptom:

Symptom	Presence (Yes/No)	Duration / Comments
Unexplained cough lasting 3+ weeks:		
Coughing up blood (Hemoptysis):		
Unexplained fever or chills:		
Night sweats (unrelated to room temperature):		
Unexplained weight loss / loss of appetite:		
Unexplained persistent fatigue:		

3. TB Risk Factor Assessment

Please type "Yes" or "No" and provide details for each risk factor:

Risk Factor	Response (Yes/No)	Details (Country, Dates, etc.)
Born in or traveled to a high-burden TB country:		
Close contact with anyone with infectious active TB:		
Immunosuppressive condition or treatment (e.g., HIV, TNF-alpha blockers):		
Resident/employee in high-risk congregate setting (e.g., prison, shelter, healthcare):		

4. Tuberculosis Testing Record

Option A: Tuberculin Skin Test (TST) / Mantoux

Date Administered (MM/DD/YYYY):		Administered By (Name/Title):	
Placement Site (e.g., Left Forearm):		Manufacturer / Lot Number:	
Date Read (48-72 hours):		Read By (Name/Title):	
Induration (mm measurement only):		Interpretation (Positive/Negative):	

Option B: Interferon Gamma Release Assay (IGRA Blood Test)

Test Type (e.g., QuantiFERON, T-SPOT):		Draw Date (MM/DD/YYYY):	
Quantitative Value:		Result (Positive/Negative/Indeterminate):	

Option C: Chest X-Ray (Required if TST or IGRA is Positive)

Date of Chest X-Ray:		Result (Normal/Abnormal):	

Findings/Comments:

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5. Healthcare Provider Evaluation & Certification

Clinical Assessment (Infectious/Non-Infectious):	
Recommendations / Treatment Plan:	
Provider Printed Name and Title:	
Facility Name and Address:	
Provider Signature (Sign upon printing):	
Date of Certification:	