Tuberculosis (TB) Clearance Form

UNIVERSITY HEALTH SERVICES
UNIVERSITY OF MASSACHUSETTS BOSTON

Name *(please print)* _____

Date of Birth (MM/DD/YY) _____

Student ID# _____

Part I. Clinical Assessment by Health Care Provider (MD/DO/PA/NP)

****Only a health care practitioner authorized to prescribe treatment may sign this form.*

History of a positive TB skin test or IGRA blood test? (If yes, document below) **Yes**_____ **No** _____

History of BCG vaccination? (If yes, consider IGRA if possible.) **Yes**_____ **No** _____

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes _____No _____

If No, proceed to 2 or 3.

If yes, check below:

- ❑ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- ❑ Coughing up blood (hemoptysis)
- ❑ Chest pain
- ❑ Loss of appetite
- ❑ Unexplained weight loss
- ❑ Night sweats
- ❑ Fever

Proceed with additional evaluation to exclude active tuberculosis disease including chest x-ray (PA and lateral) and sputum evaluation as indicated.

2. Interferon Gamma Release Assay (IGRA) *A copy of the lab report must be submitted with the clearance form.*

Date Obtained:_____/_____/_____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Date Obtained: _____/_____/_____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

3. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given:_____/_____/_____ Date Read:_____/_____/_____
M D Y M D Y

Result: ____mm of induration **Interpretation: positive_____negative_____

Date Given:_____/_____/_____ Date Read:_____/_____/_____
M D Y M D Y

Result: ____mm of induration **Interpretation: positive_____negative_____

**Interpretation guidelines:

≥5 mm is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

≥10 mm is positive:

- Foreign born or travelers to the U.S. from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

≥15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

4. Chest x-ray: (Required if IGRA or TST is positive. Note: a single PA view is indicated in the absence of symptoms**)** *A copy of the chest x-ray report must be submitted with the clearance form.*

Date of chest x-ray: _____/_____/_____ Result: normal____ abnormal____
M D Y

Part II. Management of Positive IGRA or TST

In deciding whether to recommend treatment of LTBI to individual patients, the clinician should weigh the likelihood of infection, the likelihood of progression to active tuberculosis infection, and the benefit of therapy. Students in the following groups are at increased risk of progression from LTBI to active TB disease and should be prioritized to begin treatment as soon as possible.

- ❑ Infected with HIV
- ❑ Recently infected with *M. tuberculosis* (within the past 2 years)
- ❑ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- ❑ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- ❑ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- ❑ Have had a gastrectomy or jejunoileal bypass
- ❑ Weigh less than 90% of their ideal body weight
- ❑ Cigarette and e-cigarette smokers and persons who abuse drugs and/or alcohol

Treatment History

Indicate whether treatment was administered or deferred/declined.

- ❑ Treatment was administered

  Medication(s): _____

  Start date: _____ (M / D / Y) Completion date: _____ (M / D / Y)

- ❑ Treatment deferred due to (state reason) _____

- ❑ Treatment declined by patient

_____ (____)_____

Print Name & Credentials of Health Care Provider *** **Telephone**

_____ _____ _____ _____

Address **City/Town** **State** **Zip**

_____ _____

Signature of Health Care Provider*** **Date (M / D / Y)**

****** Only a health care practitioner authorized to prescribe treatment may sign this form.***

official practice or provider stamp required