University of Pittsburgh School of Nursing
Annual TB Screening Form

PART I: Student INFORMATION

(ALL FIELDS MUST BE COMPLETED)

NAME: _____/_____/ _____
(LAST NAME) (FIRST NAME) (Middle Initial)

ADDRESS _____/ _____
(STREET) (CITY/STATE/ZIP)

TELEPHONE: _____ E-MAIL: _____

PART II: TB Screening Information (Health Care Provider must Complete)

TB Screening: One of the following is required

1. TUBERCULOSIS SKIN TEST	1. Date Read Test: ____/_____/ _____ 2. RESULT: ☐ POSITIVE ☐ NEGATIVE
2. TUBERCULOSIS QUANTIFERON GOLD BLOOD TEST	1. Date Read Test 1:_____/_____/ _____ 2. RESULT: ☐ POSITIVE ☐ NEGATIVE
CHEST X-RAY (If there was a positive TB test, at the time of this health screen or in the past, the results of the follow-up chest x-ray must to be reported and the attached symptom checklist must be completed	1. Chest X-Ray Date: _____/_____/ _____ 2. RESULT: ☐ NORMAL ☐ ABNORMAL

Name: _____

Signature:_____

Date:_____/_____/_____

Phone:_____

Medical TB Questionnaire

Please answer the following questions about signs and symptoms of tuberculosis.

Are you coughing up blood-streaked sputum and/or having chest pain while coughing?	☐ YES ☐ NO
Had you had a productive cough lasting longer than 3 weeks?	☐ YES ☐ NO
Have you had unexplained night sweats, fever, or fatigue?	☐ YES ☐ NO
Have you had unexplained loss of appetite or weight loss?	☐ YES ☐ NO

Note: ALL SECTIONS ON THIS FORM MUST BE COMPLETED BEFORE IT IS SUBMITTED!

Upon completion, this form should be scanned and uploaded by the student to EXXAT.