Assessment for Tuberculin Skin Test (TST) Reactor and/or Positive IGRA (Interferon Gamma Release Assay – TB Blood test)

Name: ______________________________ MRN: ____________________________

Department: _________________________ Email/Phone #: ______________________________

Were you born or have you lived outside of the U.S.? Yes ____ No ____
If yes, Dates: _______________ Location: ___________________________

Have you ever had the BCG vaccine? Yes ____ No ____
If yes, Date: _____________ Age: _____

Have you ever had medical treatment for TB/Latent Tuberculosis? Yes ____ No ____
If yes, Date: _____________ Where: ________________________
TB drugs and Dates: ____

Last TB skin test or TB blood test Date: ____________ Result: __________

Do you currently have any of these symptoms?

Symptom	Yes	No
Cough	Yes ____	No ____
Weight Loss	Yes ____	No ____
Night Sweats	Yes ____	No ____
Fever	Yes ____	No ____

Past Medical History:

Condition	Yes	No
Tuberculosis	Yes ____	No ____
Diabetes Mellitus	Yes ____	No ____
Steroid treatment	Yes ____	No ____
Immunosuppressive illness or treatment	Yes ____	No ____
Gastrectomy	Yes ____	No ____
Alcoholism	Yes ____	No ____
Smoking	Yes ____	No ____
Silica Exposure	Yes ____	No ____

Comments: ____

Employee Signature: ___________________________ **Date:** __________________

Fax completed form to fax # 763-7405 for review by U-M Occupational Health Services

U-M Occupational Health Services Use Only (below this line)

____ **New TST Reactor/positive IGRA (see Recommendations below)**

Current skin test: ______ mm induration Current IGRA results______________________

Previous Chest X-ray: Date: ______________________ Result: _______________

Current Chest X-ray: Date: ______________________ Result: _______________

____ **Neg IGRA Result – Annual IGRA blood test . Employee notified of recommendations___**

____ **Positive IGRA Result Employee notified to schedule latent TB treatment evaluation ______**

_____ **Annual Questionnaire – Employee unable to be tested for TB by skin or blood test**

____ **Ok** ____ **Not Ok**

Current Recommendations:

OHS return visit _______
Advised of significance of reactive tuberculin skin test/IGRA ______
Advised not to be tested in the future ______
Advised to return to OHS if TB symptoms occur ______
Referred to PCP for follow-up/treatment recommendations: ______
Convertor Yes________ No________

Health Care Provider ____ Date: ___________________

☐ Daniel Chapman MD ☐ Martin Bond PA ☐ Susan Godell NP ☐ Christine Pionk NP

☐ Cherie Holodnick RN ☐ Sandy Feldkamp RN