TUBERCULOSIS TESTING FORM

If you answer YES to any questions on your TB Screening Questionnaire, TB testing is required. Please take this form to your Health Care Provider for completion. If TB Blood Test or TB Skin Test is positive, a Chest X-ray is required. All testing and Chest X-RAY (if required) must be within 6 months of your matriculation date. Upload copy of TB test result and/or Chest X-ray report to the Student Health Portal.

**TB BLOOD TEST (IGRA)**

Preferred if prior BCG

☐ Quantiferon  ☐ T-Spot

Date:  ____/_____/____

Result  ☐ NEG  ☐ POS  ☐ INDETERMINATE

**TB SKIN TEST (TST)**

Mantoux skin test only.

Date planted:  ____/_____/____

Date Read:  ____/_____/____

Result in induration  ____ mm

If no induration, mark “0”

**CHEST X-RAY:** Required within 6 months for past or current positive TB Blood or Skin test.

Chest X-Ray Date:  ____/_____/____

Result:  ☐ NORMAL  ☐ ABNORMAL

**MEDICATION TREATMENT**

☐ Latent TB Infection  ☐ Active TB disease

Treatment Regimen:  ______________________

Duration:  _____  Completion Date: __/__/___

_________________________________________________      ______________________________

Health Care Provider Signature  Date

_________________________________________________

Health Care Provider Printed Name

Address (Print or Stamp)  ____________________________________________

City  ____________________________  State  _________  Zip  ___________

Phone (_____)  ____________________________  Fax (_____)  ____________________________

Submit completed form by scanning and uploading to the Student Health Portal – wesleyan.medcatconnect.com.