Tuberculosis (TB) Health Assessment Form
UCI Student Health Center

Name of Student _____

Date of Birth *(month/day/year)* _____

SID# _____

This student is **REQUIRED to complete tuberculosis testing** prior to enrolling in classes.
The form must be **completed and signed by a licensed health care provider** and indicated test results attached.

History Questions (ALL QUESTIONS MUST BE ANSWERED)	Yes	No	Comments
Does the student have signs/symptoms of active TB disease? (Cough greater than 3 weeks, hemoptysis, unexplained weight loss or fevers, night sweats)			If yes, evaluate as clinically appropriate.
Has the student ever been treated for latent tuberculosis infection? Medication_____ Start date_____ End date _____			If yes, please attach documentation if available. No further testing required at this time.
Has the student ever been treated for active TB disease?			If yes, must attach summary of treatment letter and most recent chest x-ray report. No further testing required at this time.

TESTING – All testing must be done within 12 months prior to enrollment.

1. Tuberculosis Test
Choose *one* of the following options:

a. TB Blood Test (Interferon Gamma Release Assay / IGRA / T-spot / Quantiferon)
Recommended if history of BCG vaccine; if not available, may do a TST or chest x-ray.
Date Obtained: _____
Result: □ Negative □ Positive (**If Positive, Proceed to #2**)
□ Indeterminate (**If Indeterminate, repeat test or proceed to #2**)

b. Tuberculin Skin Test (TST)
≥5 mm is positive if:
- Recent close contact with someone with active infectious TB disease
- Immunosuppressed (splenectomy, HIV, chemotherapy, transplant patient)
- History of an abnormal chest x-ray suggestive of TB

Otherwise ≥10mm is positive

Date placed:_____ **Date read**:_____
Result:_____mm induration. (If no induration, write Ø)

Interpretation: □ Negative □ Positive **(If Positive, Proceed to #2)**

2. Chest X-ray (***REQUIRED if TST or IGRA is positive***) ***Must attach written radiology report**
Date of chest x-ray: _____
Result: □ Normal
□ Abnormal - r/o active TB must have Sputum Induction - proceed to #3
□ Abnormal - other – Specify: _____

3. Sputum Results (AFB smear and cultures x 3 are **required** if the chest x-ray is read as concerning for TB)
#1 Date_____AFB_____Culture_____
#2 Date_____AFB_____Culture_____
#3 Date_____AFB_____Culture_____

I certify the student is free of infectious tuberculosis.

_____ _____

Signature of Licensed Healthcare Provider **Date**

Office Stamp

_____ _____

Printed Name of Licensed Healthcare Provider **MD/NP/PA**

For questions, see our FAQ Page at http://www.shs.uci.edu/Admission_Health_Requirements/AdmissionHealthRequirements-StudentHealthCenter-UCI.aspx
or send an email to: shc-immunization@uci.edu