Tuberculosis Screening Form for Heritage University BSN Students 2018-2019

Part I. STUDENT INFORMATION (please type or print legibly) This section of the form to be completed by student.

Name: ______________________________
Last First

DOB: ____/____/____ HU Student ID Number: ______________ Phone #: ______________
Mo Day Yr

REQUIRED:
Heritage University Department of Nursing follows the Tuberculosis Screening recommendations of the Centers for Disease Control and Prevention (CDC) for Health Care Providers, which are listed on this form. By signing below I acknowledge I have read and agree to comply with the Tuberculosis Screening Requirements.

✶SIGNATURE: ✶ ______________________________ **DATE:**____/____/____

(required) Mo Day Yr

Please attach copies, not original records—all documents used for administrative purposes will be destroyed. Always keep the original or a copy for your personal records. This form must be completed in its entirety and received prior to your deadline.

Return by PDF attachment to sanchez_m1@heritage.edu.

Part II. DOCUMENTATION OF INITIAL TB REQUIREMENTS: To be completed ONLY by Health Care Provider (HCP)
This section of the form should not be signed by student, parent, or spouse.

TUBERCULOSIS SCREENING: A "2-step" TB skin test (PPD) must be done **on or after 6/1/2018**. A 2-step test consists of 2 separate tests, placed and read *at least* 1, but not more than 3 weeks apart. History of BCG is ***not*** a contraindication to TB testing. **Students with negative 2-steps must submit documentation of annual TB skin testing yearly after initial screening to maintain compliance.** Chest X-rays are NOT accepted as substitutions for TB screening. IGRA (interferon gamma release assay, such as Quantiferon Gold) blood test results DO substitute for PPDs. Students electing the IGRA *must continue with annual IGRA* screening (as documented by lab report) unless they obtain a 2-step PPD. IGRAs prior to **6/1/2018**. are not accepted for the 2018-19 school year.

Note: A PPD skin test must be placed, or IGRA must be drawn, the SAME day as any live virus vaccine (MMR, Varicella) being given OR, at least 28 days after the administration of a live virus vaccine, to be considered valid. Please plan for this if one of the live virus vaccines may be needed.

TEST (PPD) #1
Placed: ____/____/____ Date Read: ____/____/____ Result: ________mm DOCUMENT RESULTS IN MM (Induration Only)
PLACED Mo Day Yr **(read 48-72 hours after placement)** Mo Day Yr

ON OR AFTER 6/1/2015

Signature/stamp of Health Care Provider: ______________________________

(For 2-step: If test #1 is negative, test #2 is done at least 1, but not more than 3 weeks later. If either test is positive, a chest x-ray is required.)

TEST #2 Placed:____/____/____ Date Read: ____/____/____ Result: ________mm DOCUMENT RESULTS IN MM (Induration Only)
Mo Day Yr (read 48-72 hours after placement) Mo Day Yr

Signature/stamp of Health Care Provider: ______________________________

OR

Date of
Negative IGRA: ____/____/____ **ON OR AFTER 6/1/2015** **(LAB REPORT MUST BE SUBMITTED WITH THIS FORM)**
Mo Day Yr

Students: If you are submitting documentation of two negative TB skin tests signed above by a health care provider, or a negative IGRA blood test result (with lab report showing result attached) then you do not need to complete the second page of this form. You have finished and can submit this page.

FOR DOCUMENTED POSITIVE TB SCREEN COMPLETE BOTH PAGES OF FORM

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NAME:____ **HU STUDENT ID NUMBER:** ________________

If TB screening results in a positive test or there is a history of a previously positive test, continue on with this portion of the form and submit BOTH pages.

POSTIVE TB SCREENING

Part III. STUDENT TB SYMPTOM SURVEY

Students with a previously positive, or newly positive TB skin test or IGRA must complete an annual questionnaire. Complete the following NOW. Then, a year from now, submit your responses through the link on the HSIP website.

Do you currently have any of the following symptoms/complaints? (Check No or Yes to each question; explain any Yes answers):

Cough lasting greater than 3 weeks?	☐ No	☐ Yes (explain):
Fever?	☐ No	☐ Yes (explain):
Night Sweats?	☐ No	☐ Yes (explain):
Unexplained Weight loss?	☐ No	☐ Yes (explain):
Unexplained loss of appetite?	☐ No	☐ Yes (explain):
Weakness/Fatigue?	☐ No	☐ Yes (explain):
Bloody sputum?	☐ No	☐ Yes (explain):
Chest Pain?	☐ No	☐ Yes (explain):

____ ____________________

Required: Student Signature **Date questionnaire completed**

Part IV. DOCUMENTATION OF POSITIVE TB SCREENING: To be completed ONLY by Health Care Provider (HCP)

This section of the form should not be signed by student, parent, or spouse.

Instructions for HCPs completing this section: Please initial each section you are authenticating. <u>A chest x-ray report or IGRA result must be submitted if indicated</u>. Your signature and credentials are requested at the end of this form. *All sections must be completed per instructions* for BSN program acceptance.

POSITIVE TB SCREENING: If student has had a positive TB skin test (**greater than or equal to 10mm**) or positive IGRA in the past another test is unnecessary. However, we need the **date and result of the positive test.** Provider verification of (verbal) history is acceptable if documentation of a prior positive PPD is not available. Lab Report *must be attached* for a positive IGRA. A chest x-ray report ***must*** be submitted for any student identified as having a positive PPD or IGRA. The x-ray must be **<u>on or after 6/1/2018</u>** unless you can provide the dates of a course of completed prophylactic treatment. Provider verification of treatment history *is acceptable*.

Positive
PPD Placed:___/____/______Date Read:____________/_____/_______ Result: ___________mm **HCP's initials:**
Mo Day Yr Mo Day Yr

(greater than or equal to 10 mm is Positive)

<u>OR</u>

Date of
Positive IGRA: _______/______/_____**(LAB REPORT MUST BE SUBMITTED WITH THIS FORM)**
Mo Day Yr

If positive PPD/IGRA: CXR **after 6/1/2018** required (older CXR only okay if prophylactic treatment has been completed) Date of CXR:________/______/______***Submit copy of the chest x-ray <u>report</u>. Do not send actual film.***
Mo Day Yr

PROPHYLACTIC TREATMENT INFORMATION:
Provider verification of (verbal) treatment history *is acceptable* if documentation is unavailable.

Rx/Medication Type: ____

Date Started: _____/_____/________ Date Ended: _____/_____/________ Length of Treatment:_____________Months **HCP's initials:**
Mo Day Yr Mo Day Yr

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HEALTH CARE PROVIDER INFORMATION

NOTE: This section must be completed by HCP (MD, DO, NP, PA, RN or other appropriate designee) for authentication. Not to be completed by student or relative.

I certify the accuracy of the dates and other information on this form: ______________________________ ____________

HCP's Signature **Date**

HCP's name printed/stamp of facility: ______________________________Phone number: ____________

Return by PDF attachment to Sanchez_m1@heritage.edu 04/25/18