COUNTY OF SANTA BARBARA
PUBLIC HEALTH DEPARTMENT
HCH TST/X-Ray/Quantiferon
Screening Form

Language: ☐ English ☐ Spanish ☐ Other

Name: Last First MI	DOB:	Sex:	Referred by:
Home Address: Zip:	Phone:	Reason for test:	
Employer or school:	Previous TST Date/Result (mm):	Previous QFT Date/Result:	If contact, TB case name:

I give consent for myself or the above named person to have a TST/QFT test and/or chest x-ray.

_____ _____ _____
Signature Date Relationship

The Public Health Department may share your TB test and X-ray results, as required for clearance, with intake staff at any homeless shelter in Santa Barbara County, including Bridge House, Casa Esperanza, Good Samaritan, Mark's House, Rescue Mission, and Salvation Army Hospitality House and Transition House. I consent to sharing my results as indicated above**.** ☐ YES ☐ NO

_____ _____
Signature Date

HIV (+) or risk factors for HIV with status unknown? ☐ YES ☐ NO Recent contact to infectious case? ☐ YES ☐ NO

Chest x-ray consistent with old healed TB (class IV)? ☐ YES ☐ NO

If person had an acute viral illness or a live vaccine within the past 4 weeks, and TST result is negative, repeat TST in 3-4 weeks.

2-step/booster?: ☐ YES ☐ NO

For all persons obtaining a TST (or) with history of a (+) TST - fill out below completely.

Symptoms of active disease and onset date:

☐ YES	☐ NO	Cough
☐ YES	☐ NO	Sputum production
☐ YES	☐ NO	Hemoptysis
☐ YES	☐ NO	Night sweats
☐ YES	☐ NO	Fever
☐ YES	☐ NO	Worsening Fatigue
☐ YES	☐ NO	Unexplained weight loss
Medical conditions (high risk for disease activation)		
☐ YES	**☐ NO**	**Malnutrition / rapid wt loss conditions**
☐ YES	☐ NO	Cancer of head / neck
☐ YES	☐ NO	Intestinal bypass or gastrectomy
☐ YES	☐ NO	Chronic malabsorption
☐ YES	☐ NO	Under weight (≥ 10% IDEAL BODY WIEGHT)

Medical conditions (high risk for disease activation):

☐ YES	☐ NO	Contact to infectious case
☐ YES	☐ NO	Documented (-) TST within last two years
☐ YES	☐ NO	Injection drug use (regardless of HIV stats)
☐ YES	☐ NO	Diabetes mellitus (IDDM/NIDDM)
☐ YES	☐ NO	Silicosis lung disease
☐ YES	☐ NO	Chronic Kidney failure dialysis
☐ YES	**☐ NO**	**Chronic Immunosuppression**
☐ YES	☐ NO	Transplant recipients
☐ YES	☐ NO	Steroid therapy> 1month
☐ YES	☐ NO	Blood/Lymph – spleen disorders (Hematologic Reticuloendothelial disease)
OB Status		
☐ YES	☐ NO	Pregnant/EDC
☐ YES	☐ NO	Breast feeding

Date of recent CXR: _____Result:_____Where:_____

TB Symptoms? ☐ YES ☐ NO **Sputa Collection**: ☐ YES ☐ NO **Referred to Disease Control** ☐ YES ☐ NO

If "yes" to any of the above questions a TST result ≥ 5mm = positive, otherwise ≥ 10 mm = positive

If 2-step testing is needed, perform two tests 1-3 weeks apart. Note: all new hire HCS staff must be 2-stepped if there is no history of a previous (+) TST or they have not had a TST within last 12 months.

Nurse (print/sign): _____ Date: _____

Date TST given: _____ Lot No.: _____ Exp: _____ Nurse (sign & print) _____

Date TST read: _____ Result (mm): _____ Pos/Neg Nurse (sign & print) _____

Date TST given: _____ Lot No.: _____ Exp: _____ Nurse (sign & print) _____

Date TST read: _____ Result (mm): _____ Pos/Neg Nurse (sign & print) _____

Date-QFT: _____ QFT Result: _____

Date-QFT: _____ QFT Result: _____

File Under X-ray Tab if PHD Patient

PATIENT LABEL
NAME
DOB
MRN

PHD-227 (3/09)