

RISD Health Services

20 Washington Place
Providence, RI 02903
(401) 454-6625 (phone)
(401) 454-6628 (fax)



Tuberculosis (TB) Screening Test

To be completed by a health care provider

Date of Birth: ___/___/___

Last Name: _____

First Name: _____

Middle Initial: _____

History of a positive TB skin test or IGRA blood test? (If yes, please document below) Yes ___ No ___

History of the BCG vaccination? Yes ___ No ___

Any signs or symptoms of active TB? Yes ___ No ___

(Cough, hemoptysis, chest pain, loss of appetite, unexplained weight loss, night sweats, and/or fever)

Select One TB test to be performed:

IGRA (Interferon Gamma Release Assay)

- Date obtained: ___/___/___
- Result:
- Positive _____ Negative _____

PPD (Tuberculin Skin Test)

(do not use with a history of a BCG vaccine)

- Date Placed ___/___/___
- Date Read ___/___/___
- Result _____ (in mm)
- Positive _____ Negative _____

If TB Test is positive or you have a history of a positive test, please complete the following:

Date of positive test: ___/___/___

- PPD _____
- IGRA _____

Chest x-ray:

Date of exam ___/___/___

- Normal
- Abnormal
- Result: _____

*Copy of chest x-ray and letter from medical provider required with all positive test results

Classification of the TB Skin Test Reaction:

An induration of 5 or more millimeters is considered positive in:
HIV-infected persons

A recent contact of a person with TB disease

Persons with fibrotic changes on chest radiograph consistent with prior TB

Patients with organ transplants

Persons who are immunosuppressed for other reasons (e.g. taking the equivalent of >15 mg/day of prednisone for 1 month or longer, taking TNF- α antagonists)

An induration of 10 or more millimeters is positive in:

Recent immigrants (<5 years) from high prevalence countries

Injection drug users

Residents and employees of high-risk congregate settings

Mycobacteriology laboratory personnel

Persons with clinical conditions that place them at high risk

Children <4 years of age

Infants, children and adolescents exposed to adults in high risk categories

An induration of 15 or more millimeters is positive in:

Any person with no known risk factors to TB

Medical Provider Name (print): _____ Date: _____

Medical Provider Signature (or stamp): _____

Address: _____

Phone: _____ Fax: _____

*Please note:

This form is required if you answered 'yes' to any questions on the TB Questionnaire

The significance of the travel exposure should be discussed with a health care provider and evaluated

Tests must be completed within 6 months prior to enrollment start date

A negative chest x-ray will not be accepted if it is not accompanied by PPD or IGRA test