Part I: Tuberculosis (TB) Screening Questionnaire

Please answer the following questions:

Have you been a resident, volunteer, and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?

☐ Yes ☐ No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?

☐ Yes ☐ No

Have you been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol?

☐ Yes ☐ No

Have you ever had close contact with persons known or suspected to have active TB disease?

☐ Yes ☐ No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country below.)

☐ Yes ☐ No

Have you resided in or traveled to one or more of the countries or territories listed below for a period of one to three months or more? (If yes, CHECK the countries or territories above)

☐ Yes ☐ No

If you answered YES to any of the above questions, Boston College requires that you receive TB testing prior to the start of your first enrolled term. The significance of any travel exposure should be reviewed with a healthcare provider.

Continue to pages 2-4

If the answer to all the above questions is NO. No further testing or further action is required.

Source: World Health Organization Global Health Observatory, Tuberculosis incidence. Countries with average incidence rates of 20 cases per 100,000 population.
Part II. Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) unless a previous positive test has been documented.

- History of a positive TB skin test or IGRA blood test? (If yes, see the document below) ☐ Yes ☐ No
- History of BCG vaccination? (If yes, consider IGRA if possible.)  ☐ Yes ☐ No

1. TB Symptom Check
   - Does the student have signs or symptoms of active pulmonary tuberculosis disease? ☐ Yes ☐ No
     - If no, proceed to 2 or 3.
     - If yes, check below:
       - Cough (especially if lasting for 3 weeks or longer) with or without sputum production
       - Coughing up blood (hemoptysis)
       - Chest pain
       - Loss of appetite
       - Unexplained weight loss
       - Night sweats
       - Fever

2. Interferon Gamma Release Assay (IGRA)
   Date Obtained: ___/___/____
   (specify method) QFT T-Spot other: ________
   Result: ☐ Negative ☐ Positive ☐ Indeterminate ☐ Borderline (T-Spot only)

   Date Obtained: ___/___/____
   (specify method) QFT T-Spot other: ________
   Result: ☐ Negative ☐ Positive ☐ Indeterminate ☐ Borderline (T-Spot only)

3. Tuberculin Skin Test (TST)

TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write “0”. The TST interpretation should be based on mm of induration as well as risk factors.) **

Date Given: ___/___/____
Result: ________mm of induration
Date Read: ___/___/____
Interpretation: ☐ Negative ☐ Positive

Date Given: ___/___/____
Result: ________mm of induration
Date Read: ___/___/____
Interpretation: ☐ Negative ☐ Positive

** Interpretation guidelines:

>5 mm is positive:
- Recent close contact of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- Organ transplant recipients and other immunosuppressed persons (including receiving the equivalent of >15 mg/d of prednisone for >1 month)
- HIV-infected persons
- Foreign-born or travelers to the U.S. from high prevalence areas or who resided in one for a significant* amount of time
- Injection drug users
- Mycobacteriology laboratory personnel
- Residents, employees, or volunteers in high-risk congregate settings
- Persons with medical conditions that increase the risk of progression to TB disease, including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight

>10 mm is positive:

>15 mm is positive:
- Persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

*The significance of the travel exposure should be discussed with a healthcare provider and evaluated.
4. Chest x-ray: (Required if IGRA or TST is positive. Note: a single PA view is indicated in the absence of symptoms.)

Date of Chest X-ray: __/____/____

Interpretation: □ normal □ abnormal

Part III. Considerations for Treatment of LTBI

In deciding whether to recommend treatment of LTBI to individual patients, the clinician should weigh the likelihood of infection, the likelihood of progression to active tuberculosis infection, and the benefit of therapy. Students in the following groups are at increased risk of progression from LTBI to active TB disease and should be prioritized to begin treatment as soon as possible.

□ Infected with HIV
□ Recently infected with M. tuberculosis (within the past 2 years)
□ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiographs consistent with prior TB disease
□ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
□ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
□ Have had a gastrectomy or jejunoileal bypass
□ Weigh less than 90% of their ideal body weight
□ Cigarette and e-cigarette smokers and persons who abuse drugs and/or alcohol

MEDICATION SECTION

Was the patient educated and counseled on latent tuberculosis and advised to take medication because of the positive results?

□ Yes  □ No

• Does the patient decline treatment at this time? □ No
• Does the patient agree to receive treatment? □ Yes
• Indicate medication(s) prescribed? Date Started: __________ Date Ended: __________

HEALTH CARE PROVIDER

Signature of Provider
Printed Name
Date

Mailing Address
Office Phone