University Health Services
2751 O'Varsity Way, 3rd Floor, Room 335
Cincinnati, Ohio 45221
Phone: 513-556-2564, Fax: 513-556-1337
UHSTracking@ucmail.uc.edu

University Health Services Registration Form

First Name	
Middle Name	
Last Name	
Gender	
Date of Birth (MM/DD/YYYY)	
Emergency Contact	**Name:**
	Phone #:
	Relationship to you:
US Address (if known)	
US Phone Number (if known)	
Email Address	
Language	
Need Interpreter?	☐ Yes ☐ No
Hearing Impaired?	☐ Yes ☐ No
Visually Impaired?	☐ Yes ☐ No
Marital Status	☐ Single ☐ Married
Ethnic Group	☐ Hispanic ☐ Latino ☐ Not Hispanic or Latino
Race/Nationality	
M#	
Semester	

University Health Services
2751 O'Varsity Way, 3rd Floor, Room 335
Cincinnati, Ohio 45221
Phone: 513-556-2564, Fax: 513-556-1337

University of Cincinnati Tuberculosis Risk Assessment

Please have your licensed medical provider review and complete the following form, evaluating history and risk factors for Tuberculosis.

First Name		**Last Name**	
M#		**DOB**	
UC Email		**Semester/Year**	

Date of Arrival to USA	
Birth Country	
Have you ever had close contact with anyone known or suspected of having **active TB disease?**	☐ No ☐ Yes If Yes, list most recent contact:
Have you ever been a resident, volunteer, and/or employee of a high-risk congregate setting such as prisons, long term care, homeless shelter?	☐ No ☐ Yes
Have you ever been a volunteer or health care worker who served people that are increased risk for active TB disease?	☐ No ☐ Yes
Have you ever been a member of any of the following high-risk groups: medically underserved, lower income, drug/alcohol abuser?	☐ No ☐ Yes
Do you have a weakened immune system (i.e. human immunodeficiency virus (HIV) infection, long-term use of prednisone (greater than 2 weeks), and/or other immune-suppressing drugs?	☐ No ☐ Yes
Do you have rheumatoid arthritis, Crohn's disease, and/or other conditions which are treated with immune suppressing drugs (i.e. Remicade, Enbrel, or Humira)?	☐ No ☐ Yes
Have you ever received the BCG vaccine (usually given as an infant or child, and leaves a scar on the upper arm)?	☐ No ☐ Yes ☐ Unknown
Do you have a history of Tuberculosis?	☐ No ☐ Yes
Have you ever been treated for Tuberculosis?	☐ No ☐ Yes If Yes, list date and treatment:
Do you have a history of a positive (abnormal) TB skin or blood test?	☐ No ☐ Yes If Yes, list type (skin or blood):
If you have completed lab or x-ray testing for Tuberculosis, was the testing done outside of the United States?	☐ No ☐ Yes
Have you received any vaccines in the last 30 days?	☐ No ☐ Yes If Yes, list here:
Circle any of the countries or territories you have lived in or spent at least 2 weeks in (*see other side of page)	

NOTE TO PROVIDER: If the patient has answered **YES** to any of the above questions or has visited a high-risk country, an IGRA blood test in the past three months is required. The student must return the completed and signed questionnaire AND proof of an IGRA blood test. Patient must complete the UC Clinical Assessment for Tuberculosis form. If IGRA is positive, the student must also have a chest xray done.

The above health statement is accurate to the best of my knowledge.

Student Signature		Date	

Screening administered by licensed healthcare professional:

Printed name and location:			
Signature		Date	

*High Risk Countries			
Afghanistan	Dominica	Libya	Romania
Algeria	Dominican Republic	Lithuania	Russian Federation
Angola	Ecuador	Madagascar	Rwanda
Argentina	El Salvador	Malawi	Sao Tome and Principe
Armenia	Equatorial Guinea	Malaysia	Senegal
Azerbaijan	Eritrea	Maldives	Senegal
Bangladesh	Eswatini	Mali	Singapore
Belarus	Ethiopia	Malta	Solomon Islands
Belize	Fiji	Marshall Islands	Somalia
Benin	French Polynesia	Mauritania	South Africa
Bhutan	Gabon	Mexico	South Sudan
Bolivia	Gambia	Micronesia	Sri Lanka
Bosnia and Herzegovina	Georgia	Moldova	Sudan
Botswana	Ghana	Mongolia	Suriname
Brazil	Greenland	Morocco	Tajikistan
Brunei Darussalam	Guam	Mozambique	Tanzania
Burkina Faso	Guatemala	Myanmar	Thailand
Burundi	Guinea	Namibia	Timor-Leste
Cabo Verde	Guinea-Bissau	Nauru	Togo
Cambodia	Guyana	Nepal	Tunisia
Cameroon	Haiti	Nicaragua	Turkmenistan
Central African Republic	Honduras	Niger	Tuvalu
Chad	India	Nigeria	Uganda
China	Indonesia	Northern Mariana Islands	Ukraine
China, Hong Kong SAR	Iraq	Pakistan	Uruguay
China, Macao SAR	Kazakhstan	Palau	Uzbekistan
Colombia	Kenya	Panama	Vanuatu
Comoros	Kiribati	Papua New Guinea	Venezuela
Congo	Kyrgyz Republic	Paraguay	Vietnam
Cote d'Ivoire	Lao People's Dem. Rep.	Peru	Yemen
Dem. Rep. of Korea	Latvia	Philippines	Zambia
Dem. Rep. of Congo	Lesotho	Qatar	Zimbabwe
Djibouti	Liberia	Rep. of Korea (S. Korea)	

University Health Services
2751 O'Varsity Way, 3rd Floor, Room 335
Cincinnati, Ohio 45221
Phone: 513-556-2564, Fax: 513-556-1337

University of Cincinnati Clinical Assessment for Tuberculosis

Please have your licensed medical provider review and complete the following form, evaluating symptoms and past history with Tuberculosis.

First Name		**Last Name**	
M#		**DOB**	
UC Email		**Phone #**	

TB Symptom Screening

Does the student have signs or symptoms of active pulmonary tuberculosis disease? ☐ Yes ☐ No

If yes, please check all that apply below:

☐ Cough (especially if lasting for 3 weeks or longer) with our without sputum production
☐ Coughing up blood (hemoptysis)
☐ Chest pain
☐ Loss of appetite
☐ Unexplained weight loss
☐ Night sweats
☐ Fever

If yes to any of the above, ***in addition to an IGRA blood test,*** proceed with evaluation to exclude active tuberculosis disease including chest x-ray (PA and lateral) and sputum evaluation as indicated.

TB Testing History

IGRA blood test within 3 months prior to the start of classes at the University of Cincinnati is required. If you have more than one IGRA blood test or chest x-ray, please list them below.

	Date Obtained	Method	Result	Lab Report Attached (*required*)
Interferon Gamma Release Assay (IGRA) T-spot/QuantiFERON TB Gold blood tests for tuberculosis		☐ QFT ☐ T-Spot	☐ Negative ☐ Positive ☐ Indeterminate	☐
		☐ QFT ☐ T-Spot	☐ Negative ☐ Positive ☐ Indeterminate	☐
		☐ QFT ☐ T-Spot	☐ Negative ☐ Positive ☐ Indeterminate	☐

	Date Obtained	Result	Chest x-ray Report Attached (*required*)
Chest x-ray Required if history of positive IGRA		☐ Normal ☐ Abnormal	☐
		☐ Normal ☐ Abnormal	☐
		☐ Normal ☐ Abnormal	☐

First Name		Last Name	
M#		DOB	
UC Email		Phone #	

TB Treatment History

Please disregard this section if you have never been treated for latent or active Tuberculosis.

	Medication Name(s)	Start Date	Stop Date	Dose	Dosing Frequency	Directly Observed Therapy (DOT)
Treatment for latent Tuberculosis infection						☐
						☐
						☐
						☐

	Medication Name(s)	Start Date	Stop Date	Dose	Dosing Frequency	Directly Observed Therapy (DOT)
Treatment for active Tuberculosis disease						☐
						☐
						☐
						☐
						☐
	Disease Location	☐ Lung ☐ Outside of Lung				

MUST BE SIGNED BY A LICENSED HEALTHCARE PROFESSIONAL:

Healthcare Professional Signature		Date
Printed Name		Office Stamp
Professional License #		
Title		
Address		

Please email completed forms and test results to UHSTracking@ucmail.uc.edu. DO NOT upload to Bearcats Health app.