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 | ☐ |

## *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** | | |