Project New Hope

LA COUNTY TUBERCULOSIS CONTROL PROGRAM

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TUBERCULOSIS SCREENING FORM FOR RESIDENTIAL HOSPICES AND SHELTERS

Patient: _____

Physician: _____ Referral Source: _____

Diagnosis

❑ TB Disease ❑ TB Suspect ❑ Mantoux Reactor Only ❑ None

Required TB Screening

CHEST X-RAY Date:_____ (Must Be Winthin 4 Weeks)

❑ Normal ❑ Abnormal:

CXR READING:

BACTERIOLOGY FOR AFB Date:_____

[Suspects and known Pulmonary TB cases must have 3 negative Sputum Smears before placement]

❑ Specimen ❑ "Smear Concentrate" ❑ Culture ❑ Pending

Anti-Tuberculosis Medication

Isoniazid: Dose _____ Date Started _____

Rifampin: Dose _____ Date Started _____

Pyrazinamide: Dose _____ Date Started _____

Ethambutol: Dose _____ Date Started _____

Recommended TB Screening

MANTOUX (PPD):* Date:_____ Reading: _____ mm

❑ "Positive by History:" ❑ Anergic: ❑ Not Done:

Based on the above information, I certify that this patient does not have communicable/infectious tuberculosis.

Signature: _____ M.D. Date: _____

Phone: _____

*Isoniazid (INH) preventive therapy is indicated for all HIV infected Mantoux reactors and should be considered
"for anergic persons from groups in which the prevalence of tuberculosis infection is high, such as contacts of "
"known cases of pulmonary TB, IDU's, prisoners, homeless persons, migrant laborers, and persons born in"
"countries in Asia, Africa and Latin America with high rates of tuberculosis."
"[For Consultation, Call L.A. County TB Control @ 213-744-6151]"

PNH/LACTB/01182011