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 Within 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]"