UCDAVIS
STUDENT HEALTH AND COUNSELING SERVICES

PRIVATE PROVIDER TUBERCULOSIS EVALUATION FORM

(To be completed by medical provider)

PLEASE RETURN THIS FORM TO:

Student Health & Counseling Services
Fax: (530) 752-5587
Attention: Dr. Schorzman

Patient Name: _____

Address: _____

Telephone Number: _____ **Date of Birth:** _____

Medical Evaluation Date: _____

TB Symptom Screen (check all that apply):

- ☐ Cough for more than three weeks
- ☐ Pain in the chest
- ☐ Blood in sputum
- ☐ Weakness
- ☐ Tiredness
- ☐ Swollen lymph node
- ☐ Unexpected weight loss
- ☐ Decreased appetite
- ☐ Poor growth
- ☐ Fever
- ☐ Chills
- ☐ Sweating at night
- ☐ Other: _____
- ☐ None of the above

Tuberculin Skin Test (TST):

Administered: _____ (*date*) _____ (*time*) **Read:** _____ (*date*) _____ (*time*)

TST Results: _____ mm (record in millimeters, induration only)

OR

IGRA Test:

Date: _____ **Result:** ☐ Negative ☐ Positive ☐ Indeterminate

*If TB symptoms are present **OR** either TST or IGRA test result is positive, please obtain chest x-ray and indicate findings below.*

Chest x-ray Date: _____ **Result:** ☐ Normal ☐ Abnormal If abnormal, ☐Cavitary or ☐Non-Cavitary

DIAGNOSIS:

- ☐ TB exposure/no infection (TB1)
- ☐ TB infection/no disease (TB2)
- ☐ Active TB (TB3)
- ☐ Inactive TB (TB4)
- ☐ Possible TB, needs further evaluation (TB5)

TREATMENT: ☐ No ☐ Yes – If yes, treatment regimen: _____

Prevent TB cases by finding and treating people with LTBI! Preferred treatment is a short course regiment:

Isoniazid + Rifapentine weekly x 12 weeks ***OR*** Rifampin daily x 4months

If a rifamycin-based regimen is not an option (due to drug resistance or intolerance), use Isoniazid daily x 9 months. For more information about LTBI treatment regimens, contact your local TB program or CDC website.

Date medication started: _____

Name of Physician: _____

Address: _____

Telephone Number: _____

Physician's signature: _____ **Date**: _____