Positive TB Screening Form

This OPTIONAL form explains documentation requirements for students who have a positive PPD or IGRA. Health care providers (MD, DO, ARNP, PA, RN or other appropriate designee) may use this form to document a positive PPD and/or completed prophylactic treatment if other documentation is unavailable. This form is not acceptable when completed by a student or relative. Students submitting this form must complete the separate REQUIRED TB Symptom Survey Form and upload all required documentation together.

Student Name: ________________________________ UW ID# __________________

PLEASE PRINT: Last name First name

Positive PPD: If student has had a positive TB skin test (greater than or equal to 10mm), note below the date and result of the positive test. If documentation is not available, the provider may verify the student’s history by noting it below.

PPD placed: ______/______/______ PPD read: ______/______/______ PPD result: ______mm

Mo Day Yr Mo Day Yr A positive result is >10 mm.

~ OR ~

Positive IGRA: A lab report must be submitted with this form (verbal history not accepted)

~ AND ~

Chest x-ray: Students with documentation of a positive PPD or IGRA must also submit either:

☐ A copy of a chest x-ray report (not the actual film) for an x-ray date after the positive TB screening AND within the current calendar year of entry into your program.

☐ The dates of a course of completed prophylactic treatment (below) and a CXR report (not the actual film) from any date after the positive TB screening.

UW health sciences students with a positive PPD or IGRA are not required to complete prophylactic treatment. For student who did complete prophylactic treatment, please complete the information below. If documentation is not available, the provider may verify the student’s treatment history by noting it below.

Rx/medication type: ____________________________________________________________

Date started: ______/______/______ Date ended: ______/______/______ Length of treatment: _____months

Mo Date Yr Mo Date Yr

For students with a history of active TB disease: Please contact HSIP at myshots@uw.edu for instructions.

Required: Health Care Provider Authentication

I certify the accuracy of the dates and other information on this form.

Signature: ____________________________________________ circle one: MD, ARNP, PA, DO, ND, RN

Printed Name: __________________________________________

Phone #: ___________________________ Date: ____________

FACILITY STAMP