



Name: _____

UW Student Number: _____

TB Symptom Checker

Part I: Student TB Symptom Survey

Students with a previously positive, or newly positive, TST or IGRA must complete an annual questionnaire. Proof of a clear chest x-ray from the last 5 years must accompany this form after it has been certified by a Health Care Provider.

Do you currently have any of the following symptoms/complaints? (Check Yes or No to each question; explain any Yes answers):

Cough lasting greater than 3 weeks?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain):
Fever?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain):
Night Sweats?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain):
Unexplained Weight loss?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain):
Unexplained loss of appetite?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain):
Weakness/Fatigue?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain):
Bloody Sputum?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain):
Chest Pain?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain):

Required: Student Signature _____

Date questionnaire completed [Click here to enter a date.](#)

Part II: Documentation of Positive TB Screening: To be completed ONLY by Health Care Provider (HCP).

Instructions for HCPs completing this section: Please initial each section you are authenticating. A chest x-ray report or IGRA result must be submitted if indicated. Your signature and credentials are requested at the end of this form. All sections must be completed per instructions for school acceptance.

Positive TB Screening: If student has had a positive TB skin test (**greater than or equal to 10mm**) or positive IGRA in the past another test is unnecessary. However, we need the **date and result of the positive test**. Provider verification of (verbal) history is acceptable if documentation of a prior PPD is not available. Lab Report *must be attached* for a positive IGRA. A chest x-ray report *must* be submitted for any student identified as having a positive PPD or IGRA. The x-ray must be from the last 5 years unless you can provide the dates of a course of completed prophylactic treatment. Provider verification of treatment history is *acceptable*.

Positive PPD Placed: Click here to enter a date.

Date Read: Click here to enter a date.

Result: _____ mm (greater than or equal to 10 mm is Positive)

HCP's initials: _____

OR

Date of **Positive IGRA:** Click here to enter a date. **(Lab Report must be submitted with this form)**

If positive PPD/IGRA: Clear x-ray (CXR) from last 5 years required (older CXR only okay if prophylactic treatment has been completed).

Date of CXR: Click here to enter a date. **Submit copy of chest x-ray report. Do not send actual film.**

Prophylactic Treatment Information:

Provider verification of (verbal) treatment history *is acceptable* if documentation is unavailable.

Rx/Medication Type: _____

Date Started: Click here to enter a date. Date Ended: Click here to enter a date.

Length of Treatment: _____ Months HCP's Initials: _____

Health Care Provider Information

Note: This section must be completed by HCP (MD, DO, NP, PA, RN or other appropriate designee) for authentication. Not to be completed by student or relative.

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

_____ Click here to enter a date.
HCP's signature (official initialing form)

_____ Click here to enter a date.
HCP's name printed and facility stamp (Required in addition to signature and date)