☐ Two-Step TST

Hawaii Department of Health - Tuberculosis Control Branch

Today's Date _____

1. Name: _____
Last First Middle Initial Maiden Name

Home Address: _____
Street Number and Name Apartment Number / Subdivision

_____
City State Zip Code

Mailing Address: _____
Street Number and Name Apartment Number / Subdivision

_____
City State Zip Code

Month Day Year
2. Date of Birth: _____ /_____ /_____
3. Age: _____
4. Sex: ☐ Male ☐ Female
5. Occupation: _____
Employer: _____
School: _____
6. Telephone Numbers:
Home: ( ) _____
Work: ( ) _____
Cell: ( ) _____
7. Physician: _____
8. Medical Insurance: _____

9. Marital Status:
☐ Married ☐ Widowed
☐ Divorced ☐ Separated
☐ Never Married

10. Country of Birth: _____
11. ☐ US Citizen ☐ Refugee
☐ Immigrant ☐ Other: _____

12. If Foreign Born: Month Day Year
Date arrived in US: _____ /_____ /_____
Date arrived in HI: _____ /_____ /_____
13. Primary language: _____

14. Race / Ethnicity (check all that apply):
☐ White / Caucasian ☐ Hawaiian ☐ Chinese ☐ Micronesian ☐ Samoan ☐ Hispanic
☐ Black / African American ☐ Filipino ☐ Korean ☐ Marshallese ☐ Guamanian or Chamorro
☐ American Indian or Alaskan Native ☐ Japanese ☐ Vietnamese ☐ Palauan ☐ Other: _____ Specify

15. **REASON FOR EXAMINATION** (check one only):
☐ A. Foodhandler ☐ C. Care / Foster Home Operator ☐ E. Health Care Worker ☐ G. Contact/Source (PHN:_____)
☐ B. Student ☐ D. Care / Foster Home Resident ☐ F. School Employee ☐ H. Immigration ☐ O. Other:_____

16. Were you sent by a Doctor? – If yes, Doctor's name: _____ ☐ Yes ☒ No
17. Have you had a previous positive skin test (swollen)?..... ☐ Yes ☐ No
18. Have you taken medicine for Tuberculosis?..... ☐ Yes ☐ No
19. Have you received any immunizations within the past 4 weeks?..... ☐ Yes ☐ No
20. **FEMALES - ARE YOU PREGNANT?**..... ☐ Yes ☐ No
21. **FEMALES - ARE YOU BREASTFEEDING?**..... ☐ Yes ☐ No

Notes (official use only):

Hawaii Pacific University

TB ID#: _____

22. Authorization for testing, release of medical information, and acknowledgement of understanding:

a) I hereby authorize the Department of Health to perform a tuberculin skin test and chest x-ray, if necessary, to the child (<18 years old), whose name appears on this form.
b) I hereby authorize the Department of Health to release any results and Chest Clinic Physician's recommendations to the doctor named above.
c) I understand that I must return in 48-72 hours for reading of the tuberculin skin test and I agree to return for any test results as instructed by Department of Health staff.
d) I understand that chest x-rays taken at the Tuberculosis Control Branch are to be used ONLY for Tuberculosis Control purposes.

Print Name: _____ Signature: _____ Date: _____/_____/_____
Patient, Parent, Guardian, or Caregiver Patient, Parent, Guardian, or Caregiver

----------** Please do not write below this line **----------

TST 1: Given: _____ Site: LFA / RFA Initials or Signature: _____
Read: _____ Result: _____mm Initials or Signature: _____
TST 2: Given: _____ Site: LFA / RFA Initials or Signature: _____
Read: _____ Result: _____mm Initials or Signature: _____

IGRA 1: Affix IGRA Label# Here Collected:_____ Initials: _____ Result: N / P / I

IGRA 2: Affix IGRA Label# Here Collected:_____ Initials: _____ Result: N / P / I

Reason for Clinic Registration
☐ Verified TB ☐ Contact
☐ Suspected TB ☐ Reactor
☐ Previous TB ☐ Converter

Census Tract: _____

SSN (last 4 digits): _____

CC#: _____

Admit Date: _____

Discharge Date: _____

INITIAL X-RAY	PHYSICIAN NOTES	RETAKE X-RAY	PHYSICIAN NOTES	FOLLOW-UP
☐ Negative for TB		☐ Negative for TB		☐ None ☐ FHC Given
☐ Suspicious		☐ No change		☐ LTBI Rx ☐ FHC Mailed
→ ☐ *Cavitary*		☐ Suspicious		☐ Admit ☐ LTBI Rx Letter
☐ Other		☐ Other		☐ Other
Date: _____		Date: _____		☐ Pt Other Letter
Initials: _____		Initials: _____		☐ PMD Letter: _____

DO NOT WRITE ON THIS SIDE
FOR DOH USE ONLY

Tuberculosis Contact Screening Form

State of Hawaii Department of Health
Tuberculosis Control Program

Contact Name:	Contact DOB: _____/_____/_____

Index Summary			
Index Patient ID:		TB Classification: ❑Class 3 (Case) ❑Class 5 (Suspect)	
CXR: ❑ Non-Cavitary ❑ Cavitary	Smear: ❑ Negative ❑ Positive (circle): +1 +2 +3 +4	NAAT: ❑ Negative ❑ Positive	Culture: ❑ Negative ❑ MTBc ❑ Pending ❑ Not MTB

Contact Exposure History		
Do you know who you are a contact of?	❑Yes ❑No ❑Unknown	Relationship to Index:
Continuous Exposure?	❑Yes ❑No ❑Unknown	Date of Last Exposure: _____/_____/_____
Place of Exposure (check all that apply):	❑Household Member ❑Contact's House ❑Worksite ❑Other:	
Length of Exposure to Index:	Duration: _____ Frequency: _____	
Contact Priority:	❑High ❑Medium ❑Low	

Contact Symptom Screening		**Onset and Duration of Symptoms**
1. Cough for ≥3 weeks duration?	❑Yes ❑No ❑Unknown	
2. Coughing up blood?	❑Yes ❑No ❑Unknown	
3. Fever?	❑Yes ❑No ❑Unknown	
4. Night sweats?	❑Yes ❑No ❑Unknown	
5. Unusual weakness or fatigue?	❑Yes ❑No ❑Unknown	
6. Unexplained weight loss?	❑Yes ❑No ❑Unknown	If yes, amount:

Note: Any contact who reports either of the following must be referred for CXR:
(1) Cough for ≥3 weeks duration and at least one other symptom *or* (2) Two "yes" responses to symptoms #2-6.

Contact Screening for Medical Risk Factors and Immunocompetency		**Date Started Medications and/or Comments**
1. Diabetes?	❑Yes ❑No ❑Unknown	
2. Current or past history of cancer?	❑Yes ❑No ❑Unknown	
3. Stomach surgery (e.g., gastrectomy or jejunoileal bypass)?	❑Yes ❑No ❑Unknown	
4. Low body weight (≥10% below ideal)?	❑Yes ❑No ❑Unknown	
5. Injection drug use?	❑Yes ❑No ❑Unknown	
6. Child <5 years old?	❑Yes ❑No ❑Unknown	
7. Kidney failure (ESRD) or on dialysis?	❑Yes ❑No ❑Unknown	
8. Taking anti-rejection medications for organ transplantation?	❑Yes ❑No ❑Unknown	
9. Taking any medications that weaken your immune system (e.g., Humira, Remicade, Enbrel, chemotherapy for cancer, or taking ≥15 mg daily of prednisone for ≥4 weeks)?	❑Yes ❑No ❑Unknown	
10. HIV positive?	❑Yes ❑No ❑Unknown	Date Tested:

Note: If there are any "yes" responses to questions 1-9, classify as a high priority contact.
If there are any "yes" responses to questions 6-10, contact is immunocompromised and must be referred for CXR.