CORRECTIONAL TUBERCULOSIS SCREENING PLAN

Inmate Name:	Date of Birth:	Date of Booking:

GENERAL INFORMATION

Name of Facility:		Jail Administrator:	
Physical Address:	**City:**	**County:**	**Zip:**
Mailing Address:	**City:**	**County:**	**Zip:**
Email Address:	**Phone Number:**	**Fax Number:**	
Name/Job Title of Contact Person:	**Email Address of Contact Person:**	**Phone Number:**	
Facility Operated By: ❒County ❒State ❒Other: _____	**Total Number of Employees:**	**Capacity:**	**Current Population:**

TB RISK FACTORS:

1. Has the patient had a chest x-ray that showed possible TB?	❒Yes ❒No	If yes, when: _____/_____/_____
2. Has the patient had recent contact with an infectious TB patient?	❒Yes ❒No	
3. Has the patient ever tested positive for HIV?	❒Yes ❒No	
4. Does the patient have any history of immunosuppressive disease or take medications that might cause immunosuppression?	❒Yes ❒No	If yes, name of disease and medications: _____
5. Has the patient previously been incarcerated?	❒Yes ❒No	If yes, name of jail: _____

TB SYMPTOMS:

If TB symptoms are present, promptly refer for a chest x-ray and full medical examination. Do not wait for the tuberculin skin test (TST) or TB blood test result.

1. Coughing (>3 weeks) or recent change in cough?	❒Yes ❒No
2. Coughing up blood?	❒Yes ❒No
3. Night sweats?	❒Yes ❒No
4. Weight loss/poor appetite?	❒Yes ❒No
5. Fatigue?	❒Yes ❒No
6. Chest pain?	❒Yes ❒No
7. Fever/chills?	❒Yes ❒No

TREATMENT HISTORY: Date of Screening: _____/_____/_____

Primary Reason for Evaluation: ❒Contact Investigation ❒Targeted Testing ❒Other: _____

1. Ever had an adverse reaction to a TST?	❒Yes ❒No ❒Unknown
2. Ever had a positive reaction to a TST?	❒Yes ❒No ❒Unknown
3. Ever had a positive reaction to a TB blood test (IGRA)?	❒Yes ❒No ❒Unknown
4. Ever had BCG vaccine?	❒Yes ❒No ❒Unknown
5. Ever been treated for latent TB infection or active TB?	❒Yes ❒No ❒Unknown

TESTING:

Tuberculin Skin Test (TST/Mantoux/PPD) **Date Given: _____/_____/_____** **Date Read: _____/_____/_____**	**Induration: _____ mm** **Impression:** ❒Negative ❒Positive
Interferon Gamma Release Assay (IGRA) **Date: _____/_____/_____** ❒ QuantiFERON® ❒ T-SPOT®	**Impression:** ❒Negative ❒Positive ❒Indeterminate
Chest X-ray (required with positive TST or IGRA) **Date: _____/_____/_____**	**Impression:** ❒Normal ❒Abnormal findings
❒ **LTBI treatment** (Rx and start date): Rx:_____ Date: _____/_____/_____ ❒ **Contraindications to INH or rifampin for LTBI**	❒ **Prior TB/LTBI treatment** (Rx and duration): Rx: _____ _____mm ❒ **Offered but refused LTBI treatment**

ADDITIONAL COMMENTS:

_____

_____

_____

_____

RECOMMENDATIONS:

_____

_____

_____

_____

Health Provider Signature: _____ **Date Completed: ____/____/____**