☐ Two-Step TST

Hawaii Department of Health - Tuberculosis Control Branch

English

Date Today: _____/_____/_____ Month Day Year

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

2. Date of Birth: _____ 3. Age: ___
4. Sex (at birth): ☐ Male ☐ Female
5. Occupation: _____
Employer/School: _____
6. Home Phone: ( ) _____
Work Phone: ( ) _____
Cell Phone: ( ) _____
7. Email: _____
8. Health Care Provider: _____
9. Insurance: _____

10. Country of Birth: _____
11. If not born in US: Month Year
Date arrived to US: _____ /_____
Date arrived to HI: _____ /_____
12. Citizenship: ☐ US Citizen ☐ Immigrant ☐ Refugee ☐ Other: _____
13. Preferred language: _____

14. Race / Ethnicity: (please check all that apply)

☐ Amer Indian ☐ Alaska Native ☐ Chinese ☐ Hispanic ☐ Marshallese ☐ FSMicronesia (Chuuk, Kosrae) (Pohnpei, Yap) ☐ Vietnamese
☐ Black/African American ☐ Filipino ☐ Japanese ☐ Palauan ☐ White / Caucasian
☐ Chamorro (Guam/Saipan) ☐ Hawaiian ☐ Korean ☐ Samoan ☐ Other: _____ Specify

15. Reason for Tuberculosis screening: (please check one only)

☐ Food handler ☐ Health Care Worker ☐ Day Care / Day Care Employee
☐ Student ☐ School Employee ☐ Foster Parent
☐ Care / Foster Home Operator ☐ Contact/Source (PHN: _____) ☐ Housing or Shelter Clearance
☐ Care / Foster Home Resident ☐ Immigration ☐ Other: _____

16. Do you have any of these health problems? ☐ Smoking ☐ Kidney Disease/Dialysis ☐ Diabetes ☐ Cancer (Type: _____)

17. Have you ever stayed at a homeless shelter / jail / prison / nursing home / group home? ☐ Yes ☐ No
18. Were you sent by a health care provider? – If yes, name: _____ ☐ Yes ☐ No
19. Have you had a previous positive skin test (swollen)?……...…… ☐ Yes ☐ No
20. Have you taken medicine for Tuberculosis in the past?.....…… ☐ Yes ☐ No
21. Have you received any immunizations within the past 4 weeks?…….…… ☐ Yes ☐ No
22. **FEMALES - ARE YOU PREGNANT?** ……..…… ☐ Yes ☐ No

Please turn this page over and complete your TB Risk Assessment on page 2.

Then sign below to authorize testing, release of medical information, and acknowledgement of understanding:

1. I authorize the Department of Health (DOH) to perform a tuberculin skin test and chest x-ray (if necessary) to the child (<18 years old) named on this form.
2. I authorize DOH to release TB test results and send recommendations to my health care provider.
3. **I will return in 48-72 hours for reading of my TB test.**
4. I understand that chest x-rays taken at the Tuberculosis Control Branch are interpreted for Tuberculosis Control purposes only. (Only for TB and not for other diseases.)
5. By signing below, I verify that the information above is true and accurate.

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

Hawaii Department of Health - Tuberculosis Control Branch (page 2)

Please complete this TB Risk Assessment for Person Needing Clearance	
☐Yes ☐No	1. Do you have a cough that has lasted for 3 weeks or longer?
☐Yes ☐No	2. Were you born in a country **other than** the United States, Canada, Australia, New Zealand, or Western and North European countries?
☐Yes ☐No	3. Have you lived in or traveled to (for 4 or more weeks) a country **other than** the United States, Canada, Australia, New Zealand, or Western and North Europe?
☐Yes ☐No	4. At any time, have you been around someone who was sick with *TB disease*? (Do not check "Yes" if exposed only to someone with latent TB infection.)
☐Yes ☐No	5. Do you have a health problem or do you plan to be on medical treatment that may affect the immune system? *Includes HIV/AIDS, organ transplant, treatment with TNF-alpha antagonist (ex: Humira, Enbrel, Remicade) or steroid medication for a month or longer.*
☐Yes ☐No	6. *For persons under age 16 only:* Is someone in the child's household from a country **other than** the United States, Canada, Australia, New Zealand, or Western and North Europe?

For office use only:

Primary Assessment: ☐ Issue ☐ Further eval Initial: ____

Secondary Assess: (Question 1): ☐ Issue ☐ Further eval Initial: ____

☐ Coughing up blood ☐ Fever ☐ Night sweats
☐ Unexplained weight loss ☐ Fatigue ☐ Unusual weakness ☐ No symptoms

TB ID#: _____ CC ID#: _____

Prior TST _____mm Year: _____

Tx LTBI? ☐No ☐Incomplete ☐Completed: ____

TST 1: Given: ___/___/___ Site: LFA / RFA Initials: _____
Read: ___/___/___ Result: _____mm Initials: _____

TST 2: Given: ___/___/___ Site: LFA / RFA Initials: _____
Read: ___/___/___ Result: _____mm Initials: _____

IGRA 1: Date: ___/___/___ Result: N / P / I / B Initials: ___

IGRA 2: Date: ___/___/___ Result: N / P / I / B Initials: ___

(Neighbor Islands) Date of CXR Referral: ___/___/___

INITIAL X-RAY
☐ Negative for TB ☐ Possible TB
☐ Abnormal not TB ☐ Unchanged
☐ Other: _____
Date: ___/___/___ Initials: _____

PHYSICIAN ASSESSMENT – INITIAL
_____
_____
_____
_____Priority LTBI? ☐ Yes ☐ No

PLAN:
☐ Admit w/u ☐ LTBI Tx ☐ No LTBI
☐ Follow up: _____
SURVEY:
☐ LTBI HiR Letter ☐ PMD Letter
☐ LTBI LoR Letter ☐ Mailed TBC
☐ Other Letter: _____

FOLLOW-UP X-RAY
☐ Negative for TB ☐ Possible TB
☐ Abnormal not TB ☐ Unchanged
☐ Other: _____
Date: ___/___/___ Initials: _____

PHYSICIAN ASSESSMENT – FOLLOW-UP
_____
_____
_____
_____ Priority LTBI? ☐ Yes ☐ No

PLAN:
☐ Admit w/u ☐ LTBI Tx ☐ No LTBI
☐ Follow up: _____
SURVEY:
☐ LTBI HiR Letter ☐ PMD Letter
☐ LTBI LoR Letter ☐ Mailed TBC
☐ Other Letter: _____