TCNJ THE COLLEGE OF NEW JERSEY

# PHYSICIAN'S EVALUATION FOR TUBERCULOSIS

**Completion of this form by a physician, PA or NP is REQUIRED only if you (the student) answered YES to one or more questions on the Tuberculosis Screening Questionnaire in the NEW STUDENT MEDICAL HISTORY in OWL.**
**Completion of this form REQUIRES an office visit to a healthcare provider and then must uploaded to OWL.**

**Student's Name:** _____ **Birth date:** ____/____/____ **I start TCNJ classes on** _____.
*Last* *First* *M D Y*

**Healthcare provider: Your patient has identified risk factors on a college screening questionnaire that places them at higher risk for TB infection and disease. Please complete the following evaluation.**

**1.** Has the student had a TB TEST in the past? ☐ Yes ☐ No ☐ Unknown

**2.** Has the student had a POSITIVE TB test in the past? ☐ Yes ☐ No

If YES, what test was positive: ☐ Interferon-Gamma Release Assay (IGRA) ☐ TB skin test – Result in mm:_____

Date of Positive Test: ____/____/____
*M D Y*

Chest X-Ray Date: ____/____/____ (Copy of Radiologist's report in ENGLISH must be attached) Result: Normal ☐ Abnormal ☐
*M D Y*

Diagnosis: ACTIVE Tuberculosis ☐ Yes ☐ No LATENT Tuberculosis ☐ Yes ☐ No

Treatment: _____ Completed successfully on ____/____/____
*M D Y*

**3**. **TB SYMPTOM CHECK:** Does the student have signs or symptoms of active pulmonary tuberculosis disease?

**No** ☐ Proceed to #4

**Yes** ☐ Check symptoms present & proceed with additional evaluation to exclude active tuberculosis disease including tuberculin testing, chest x-ray, and sputum evaluation as indicated.

- ☐ Cough (especially if lasting 3 weeks or longer) with or without sputum production
- ☐ Coughing up blood (hemoptysis)
- ☐ Chest pain
- ☐ Loss of appetite
- ☐ Unexplained weight loss
- ☐ Night sweats
- ☐ Fever

**4. TB TEST -** If no history of a Positive TB test, perform one of the following tests **no sooner than 6 months before the start of school:**

- **Preferred Method:** Interferon Gamma Release Assay (IGRA): ____/____/____ Neg ☐ Pos ☐ **Lab report must be provided.**
  *M D Y*

OR

- TB Skin Test placed: ____/____/____ TB Skin Test read: ____/____/____ Result **in mm**: _____mm Interpret: Neg ☐ Pos ☐
  *M D Y* *M D Y*

**5. If TB Test is positive, CHEST X-RAY is required. Radiologist's report of findings must be provided.**

Date: ____/____/____ Interpretation: Normal ☐ Abnormal ☐ Explain:_____
*M D Y*

**Diagnosis:** ACTIVE Tuberculosis ☐ Yes ☐ No LATENT Tuberculosis ☐ Yes ☐ No Other: _____

**Latent Tuberculosis Infection Resources & Treatment Guidelines for Providers are available at https://www.cdc.gov/tb/publications/ltbi/ltbiresources.htm**

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**Office Stamp (REQUIRED)**

**NOT VALID unless signed, dated, and stamped by a MD/DO, PA or NP**

Print Name & Title: _____

Signature:_____

**Date:** _____ Office Telephone: ( )_____