Appalachian® STATE UNIVERSITY

APP STATE Box 32151, Boone, NC 28607-2151

Department of Nursing Initial Tuberculosis Testing

Please copy for your records before turning in to the compliance system.

NAME: _____

Banner ID: _____

Tuberculin skin Test (TST)

Administered 0.1 intradermal

Date: _____ Time: _____

Arm (circle one): Left Right

Lot Number: _____ Expiration Date: _____

Administered by: _____

Interpretation in 48-72 hours

Date: _____ Time: _____

Results: _____ mm Circle one: Positive / Negative

Interpreted by: _____

Tuberculin skin Test (TST) ***7-21 days after test #1***

Administered 0.1 intradermal

Date: _____ Time: _____

Arm (circle one): Left Right

Lot Number: _____ Expiration Date: _____

Administered by: _____

Interpretation in 48-72 hours

Date: _____ Time: _____

Results: _____ mm Circle one: Positive / Negative

Interpreted by: _____

Interferon Gamma Release Assay (IGRA: QuantiFerson Gold or T Spot)

Date lab obtained: _____ Time: _____

Lab Name: _____

Lab Address: _____

Attach a copy of the Lab Document to this form

Chest X Ray (CXR) required for any positive tuberculosis screening test

Date of CXR: _____

Active Disease detected(cirecle one): Yes No

Attach a copy of the Radiology Report to this form

Tuberculosis Risk Assessment completed and attached to this form

PROVIDER COMPLETING FORM (*May by RN, MD, DO, NP, or PA*)

Provider Name: _____

Provider Signature: _____

Provider Address: _____

Provider Phone: _____

STUDENT:

I understand that the Department of Nursing at ASU will share health and immunization information with appropriate clinical agencies or in the event of a medical emergency.

Signature: _____

Date: _____