BEAVER COLLEGE OF
Health Sciences
APPALACHIAN STATE UNIVERSITY

Department of Nursing
Tuberculosis Testing Record: Annual
This form should be completed and submitted to the compliance system.

APP STATE Box 32151, Boone, NC 28607-2151
Please copy for your records before turning in to nursing office.

Name:_____ **Banner ID #:** _____

TUBERCULOSIS (TB) SCREENING TEST:
Annually (364 days or less after initial tb testing) one of the following is required:
One tst or
IGRA test for tuberculosis.
Upon request of a clinical agency, additional TB testing may be required.

TST 0.1ml intradermal in the left arm.
READ IN 48-72 HOURS.
Date/Time administered: _____ By:_____

Date/Time read: _____Results:_____mm
By: _____

OR

IGRA (Quantiferon Gold or T-Spot)
Date and Results: _____
Attach an official copy of the results to this form.

Chest x-ray required if any TB screening test is positive, yearly for two years after first converting to positive. And every 5-6 years thereafter.

Date of x-ray:_____Absence of active disease: Yes No

Attach Radiology Report and fill out Annual Tuberculosis Surveillance Questionnaire.

If medication for latent tuberculosis has been completed, documentation should be provided.

Comments:

_____

Provider Signature: _____ **Date:** _____

Nurse, MD, PA, FNP who completed any of the above

Address:_____

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

Signature:_____Date: _____