



APPALACHIAN STATE UNIVERSITY

BEAVER COLLEGE OF HEALTH SCIENCES

Nursing

**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: _____