KITSAP PUBLIC
HEALTH DISTRICT

345 6th Street, Suite 300
Bremerton, WA 98337
360-728-2235

TUBERCULOSIS INFECTION SCREENING FORM

Print clearly and fax to (360) 813-1168.

POSITIVE TEST RESULT		REPORT DATE
☐ *TST*	*date:*______________	
☐ *QuantiFERON Gold*	*date:*______________	
☐ *T SPOT*	*date:*______________	

PATIENT INFORMATION

Patient's name (last, first and middle initial)

Date of birth (m/d/yyyy) *Gender*

☐ Male ☐ Female

Patient address

City *State* *Zip code*

Phone number (home) *Country of birth*

REPORTER INFORMATION

Person reporting (name and title)

Facility name

Phone number *Fax number*

Facility address

City *State* *Zip code*

ADDITIONAL INFORMATION

Reason for testing:

☐ Exposure ☐ Work requirement ☐ School requirement ☐ Symptomatic ☐ Pre-treatment screening for immunosuppressive therapy

☐ Other: ____

TB risk factors:

☐ Non-US born ☐ TB exposure ☐ Travel ☐ Immunocompromised ☐ Diabetic ☐ Other: _________________________

Additional screening completed to rule out TB disease:

☐ Chest x-ray Results: ______ ☐ Physical exam Results:______ ☐ Sputum collection Results: ______ ☐ Symptom screen (No fever, night sweats, weight loss, cough, or hemoptysis)

Decision to treat for LTBI:

☐ H3P ☐ 4R ☐ 3HR ☐ 6H ☐ 9H ☐ Not treating at this time*

*If not initiating treatment now, please provide explanation: ____

COMMENTS: