IUPUI

CAMPUS HEALTH

INDIANA UNIVERSITY–PURDUE UNIVERSITY
Indianapolis

Tuberculosis Surveillance

Name (**PRINT LEGIBLY**): _____ _____ Date of Birth: ____/____/____

LAST FIRST MI Mo Day Year

Gender: M / F Student ID#:_____ Phone:(_____)_____ Email:_____

Purpose: Annual / New Hire / Exposure / Other _____

Affiliation: Faculty / Resident / Fellow / Staff / Student Graduating Class of: _____

Dept/Program: Medicine / Nursing / Dentistry / Health/Rehab Science / Other: _____

Are you also employed by IU Health Physicians? □ **YES** □ **NO** If Yes, what Department? _____

Allergies: _____ **History of BCG: Yes / No** **History of + TST Results: Yes / No**

TST

Placement

Date: _____
Time: _____
Forearm Site: LEFT / RIGHT
Solution: TUBERSOL / APLISOL
Lot#: _____
Expiration Date: _____
Given By: _____

Must be read *within* **48 – 72** hours of administration

Results

Date: _____
Time: _____
Result: NEGATIVE / POSITIVE
Induration _____ mm
Read By: _____

Read **AFTER** Date: _____ Time: _____
Read **BEFORE** Date: _____ Time: _____

T-Spot Date: _____ Time: _____ Result:_____

TB Questionnaire Completion Date:___ Asymptomatic / Symptomatic *(Circle One)* Compliant Until: _____

Proof of Negative CXR after +TST: Yes / No Signed:_____

If you are a Medical Staff member at an IU affiliated hospital, please email documentation of TB surveillance to the applicable Medical Staff Office:
IU Health Medical Staff iuhealthCVO@iuhealth.org (fax)317-968-1060
Eskenazi Medical Staff Office Carl.SchildtKnecht@eskenzihealth.org (fax)317-880-0302
Roudebush VA Medical Staff Office Mary.Rearick@va.gov (fax)317-988-8382

TB Surveillance is valid for one year. I acknowledge receipt and copy of my TB Surveillance Results.

Last Name: _____ First Name: _____

Signature: _____

Return completed forms by:

Fax: 317-278-6929 Scanning: healthsv@iupui.edu Campus Mail: CF 100

B 22.1 Attachment A Rev 03/23/2016
D 8.1 Attachment F Rev 03/23/2016
E 14.2 Attachment C Rev 03/23/2016