SCHOOL OF TECHNOLOGY & STUDENT SERVICES (TSS)
Health Services Center
Phone: (671) 735-5586/5644/8889 Email: gcc.healthcenter@guamcc.edu

GCC TUBERCULOSIS SCREENING FORM

PLEASE SUBMIT FOR CLEARANCE REQUEST FOR PATIENTS HAVING POSITIVE TB INFECTION

NAME: ____ **DOB:** ____

HOME ADDRESS: ________________________________ **ETHNICITY:** _________________________________

MAILING ADDRESS: _____________________________ **PHONE NUMBERS:** ___________________________

GCC ID: ____

Please check one that applies to you: ( ) Student ( ) Employee – Work Location: _______________________________

Rationale:For Employees: Section 25103, Title 10 of the Guam Code Annotated requires that all individuals working in a public or private educational institution submit annually a copy of the TB test result and be declared free of communicable disease. *(This form has been revised to incorporate revisions made on the updated Tuberculosis (TB) Evaluation Form from the Department of Public Health & Social Services, hereinafter referred to as "DPHSS", Bureau of Communicable Disease Control, Tuberculosis/Hansen's Disease Control Program. The Tuberculosis (TB) Evaluation Form has been updated by DPHSS on August 01, 2020, and effective for use at all medical clinics on November 1, 2020.)*

For Students: Guam Public Law 22-130 mandates all students to provide the school official a copy of the TB test result. The law also requires that a student with a positive test result obtain a Certificate of Tuberculosis Evaluation from the Department of Public Health & Social Services, Dededo location. *(This form has been revised to incorporate revisions made on the updated Tuberculosis (TB) Evaluation Form from the Department of Public Health & Social Services, hereinafter referred to as "DPHSS", Bureau of Communicable Disease Control, Tuberculosis/Hansen's Disease Control Program. The Tuberculosis (TB) Evaluation Form has been updated by DPHSS on August 01, 2020, and effective for use at all medical clinics on November 1, 2020.)*

Direction: Thoroughly read the following steps below and do what is indicated. You may be required to proceed to the next step. **Steps shown below must be completed by a licensed provider: physician (MD), physician's assistant (PA), or nurse practitioner (NP)**. Refer to each item below for specifics:

1. Start with step 2 if you never had a TB test before; or the previous result was negative. If you have had a history of positive TB test, you do not need to have another TB test administered. You may proceed to item 4.

2. The TB skin test can be administered by a School Health Counselor at the Health Services Center. If a student is a minor, a parent or a guardian has to accompany the student or a parental consent has to be provided in writing. You will be instructed to return to the Health Center within 48-72 hours for the reading. If more than 72 hours have elapsed and you failed to have the test read, the test must be repeated and you may be charged twice on the health fee.

3. If the skin test result is negative, your TB health requirement for enrollment has been completed. **If your skin test result is positive, proceed to item 4. Have a health care provider complete this section.**

The repeat of a TB skin test, if a client fails to show up for a scheduled reading, and the interpretation of TB skin test reading will be based on the protocol established by the TB section of DPHSS.

Public Law 22-130 requires that any individual entering from an area other than the United States or territories must have the test conducted within 6 months prior to enrollment.

Has the client been a resident of the U.S. or any of its territories within 6 months prior to this TB test administration?
Yes _______ No _______ If no, where did you reside? ____

PPD SKIN TEST	Date given:	Date read:	Result:	Reading: mm	Certified by:
IGRA TEST	Date given:	Test Type:	Result:		Certified by:

NAME: ____ DATE OF BIRTH: _____________________

4. *Has the patient been exposed to active TB in the last two (2) years?* □ *Yes* □ *No*

SYMPTOMS ≥ 2 WEEKS	YES	NO		DOES THE PATIENT HAVE A HISTORY OF:
Cough				Cancer □ Yes □ No Type: __________________
Fever				Hepatitis □ Yes □ No
Weight Loss				Kidney Disease □ Yes □ No On dialysis? □ Yes □ No
Night sweats				Rheumatoid Arthritis (Joint Pain) □ Yes □ No
Fatigue				HIV/AIDS □ Yes □ No On medications? □ Yes □ No
Chest pain				Other/Note: ______________________________________
Shortness of breath				
Hoarseness				

If response is "yes" to any of the symptoms or CXR is abnormal, patient will need a repeat (2) view CXR or follow the Radiologist' recommendations before referral to Public Health for clearance

Chest X-ray
(copy of report **MUST** be attached)

Date of CXR: _______________ □ Normal □ Abnormal

Comments: ____

REPEAT CXR
(if applicable, copy of report **MUST** be attached)

Date of CXR: _______________ □ Normal □ Abnormal

Comments: ____

NOTE: If active TB is suspected, refer by call or email to the Tuberculosis/Hansen's Disease Control Program
Phone: (671) 687-4388 / Email: tb.program@dphss.guam.gov

LTBI TREATMENT: □ 3HP □ INH □ RIF Other: ____________________________________

Date Started: ____________ Date completed: ____________________________

□ Refused Date Refused: ________________ Reason for refusing: ____________

Adverse reactions to LTBI therapy? □ Yes □ No

By signing this form, I, ________________________(*Name of licensed provider (MD/NP/PA)*), am certifying that I have ruled out active TB and the patient is cleared for work/school.

____

NAME OF CLINIC **PHYSICIAN SIGNATURE/STAMP** **Date Official Stamp**

____

Checklist for GCC Health Services Center

______________________ Date this form to indicate when the required documentation was received.

Cleared by the Health Services Center:

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Full Name of Clearing Person Full Signature of Clearing Person Date