



Two-Step TST

English

1. Name: _____ Last First Middle Initial Maiden Name				2. Date of Birth: _____	3. Age: ____
Home Address: _____ Street Number and Name Apartment Number / Subdivision				4. Sex (at birth): <input type="checkbox"/> Male <input type="checkbox"/> Female	
_____ City State Zip Code				5. Occupation: _____ Employer/School: _____	
Mailing Address: _____ Street Number and Name Apartment Number / Subdivision				6. Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____	
_____ City State Zip Code				7. Email: _____	
				8. Health Care Provider: _____	
				9. Insurance: _____	

10. Country of Birth: _____ 11. If not born in US: _____ Date arrived to US: _____ 12. Citizenship: US Citizen
 Immigrant Refugee
13. Preferred language: _____ Date arrived to HI: _____ Other: _____

14. Race / Ethnicity: (please check all that apply)
 Amer Indian Alaska Native Chinese Hispanic Marshallese FSMicronesia Vietnamese
 Black/African American Filipino Japanese Palauan (Chuuk, Kosrae) White /Caucasian
 Chamorro (Guam/Saipan) Hawaiian Korean Samoan (Pohnpei, Yap) Other: _____
Specify

15. Reason for Tuberculosis screening: (please check one only)
 Food handler Health Care Worker Day Care / Day Care Employee
 Student School Employee Foster Parent
 Care / Foster Home Operator Contact/Source (PHN: _____) Housing or Shelter Clearance
 Care / Foster Home Resident Immigration Other: _____

16. Do you have any of these health problems? Smoking Kidney Disease/Dialysis
 Diabetes Cancer (Type: _____) None

17. Have you ever stayed at a homeless shelter / jail / prison / nursing home / group home? Yes No
18. Were you sent by a health care provider? – If yes, name: _____ Yes No
19. Have you had a previous positive skin test (swollen) or blood test?..... Yes No
20. Have you taken medicine for Tuberculosis in the past?..... Yes No
21. Have you received any immunizations within the past 4 weeks?..... Yes No
22. **FEMALES - ARE YOU PREGNANT?** Yes No

Please turn this page over and complete your TB Risk Assessment on page 2.
Then sign below to authorize testing, release of medical information, and acknowledgement of understanding:

- I authorize the Department of Health (DOH) to perform a tuberculin skin test and chest x-ray (if necessary) to the child (<18 years old) named on this form.
- I authorize DOH to release TB test results and send recommendations to my health care provider.
- I will return in 48-72 hours for reading of my TB test.**
- I understand that chest x-rays taken at the Tuberculosis Control Branch are interpreted for Tuberculosis Control purposes only. (Only for TB and not for other diseases.)
- By signing below, I verify that the information above is true and accurate.

Print Name: _____ Signature: _____ Date: _____
Patient, Parent, Legal Guardian, or Caregiver Patient, Parent, Legal Guardian, or Caregiver



Please complete this TB Risk Assessment for Person Needing Clearance	
<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Do you have a cough that has lasted for 3 weeks or longer?
2. Where were you born? _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. In your lifetime, have you traveled or lived outside the United States? If yes, where and for how long? _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. At any time, have you been around someone who was sick with <i>TB disease</i> ? (Do not check "Yes" if exposed only to someone with latent TB infection.)
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Do you have a health problem or do you plan to be on medical treatment that may affect the immune system? <i>Includes HIV/AIDS, organ transplant, treatment with TNF-alpha antagonist (ex: Humira, Enbrel, Remicade) or steroid medication for a month or longer.</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. <i>For persons under age 16 only:</i> Is someone in the child's household from another country? Which one? _____
If you need a test, which office will you go to for the test? <input type="checkbox"/> Lanakila <input type="checkbox"/> EHon <input type="checkbox"/> Leeward <input type="checkbox"/> Neighbor Island _____ <input type="checkbox"/> Other _____	

For office use only:

Primary Assessment: <input type="checkbox"/> Issue <input type="checkbox"/> Further eval Initial: _____	TB ID#: _____ CC ID#: _____	
Secondary Assess: (Question 1): <input type="checkbox"/> Issue <input type="checkbox"/> Further eval Initial: _____ <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Unusual weakness <input type="checkbox"/> No symptoms	Prior TST _____mm Year: _____ Tx LTBI? <input type="checkbox"/> No <input type="checkbox"/> Incomplete <input type="checkbox"/> Completed: _____	
TST 1: Given: ___/___/___ Site: LFA / RFA Initials: _____ Read: ___/___/___ Result: _____mm Initials: _____	IGRA 1: Date: ___/___/___ Result: N / P / I / B Initials: _____ IGRA 2: Date: ___/___/___ Result: N / P / I / B Initials: _____	
TST 2: Given: ___/___/___ Site: LFA / RFA Initials: _____ Read: ___/___/___ Result: _____mm Initials: _____	(Neighbor Islands) Date of CXR Referral: ___/___/___	
INITIAL X-RAY <input type="checkbox"/> Negative for TB <input type="checkbox"/> Possible TB <input type="checkbox"/> Abnormal not TB <input type="checkbox"/> Unchanged <input type="checkbox"/> Other: _____ Date: ___/___/___ Initials: _____	PHYSICIAN ASSESSMENT – INITIAL _____ _____ _____ Priority LTBI? <input type="checkbox"/> Yes <input type="checkbox"/> No	PLAN: <input type="checkbox"/> Admit w/u <input type="checkbox"/> LTBI Tx <input type="checkbox"/> No LTBI <input type="checkbox"/> Follow up: _____ SURVEY: <input type="checkbox"/> LTBI HiR Letter <input type="checkbox"/> PMD Letter <input type="checkbox"/> LTBI LoR Letter <input type="checkbox"/> Mailed TBC <input type="checkbox"/> Other Letter: _____
FOLLOW-UP X-RAY <input type="checkbox"/> Negative for TB <input type="checkbox"/> Possible TB <input type="checkbox"/> Abnormal not TB <input type="checkbox"/> Unchanged <input type="checkbox"/> Other: _____ Date: ___/___/___ Initials: _____	PHYSICIAN ASSESSMENT – FOLLOW-UP _____ _____ _____ Priority LTBI? <input type="checkbox"/> Yes <input type="checkbox"/> No	PLAN: <input type="checkbox"/> Admit w/u <input type="checkbox"/> LTBI Tx <input type="checkbox"/> No LTBI <input type="checkbox"/> Follow up: _____ SURVEY: <input type="checkbox"/> LTBI HiR Letter <input type="checkbox"/> PMD Letter <input type="checkbox"/> LTBI LoR Letter <input type="checkbox"/> Mailed TBC <input type="checkbox"/> Other Letter: _____