

Tuberculosis Screening for Nursing

Please submit **Two** copies and original of all material to Health Services. Health Services will **Not** make copies for you.
Whiteout renders forms null and void.

– To be completed by Health Practitioner (MD, DO, NP, or PA) –

Student Information (Please print):

CUNYFIRST ID No.: _____ Last four digits of S.S. No.: _____

Last Name: _____ First Name: _____ Birth Date: ____ / ____ / ____

Gender: Male _____ Female _____ Trans. (specify) _____ Other (specify) _____

QuantIFERON-TB Gold (*lab report required*)

- Chest x-ray report required only for **positive** QuantiFERON-TB Gold

Note: All students with a history of positive TST or positive QFTB-Gold, including those who have previously received BCG vaccination, are required to submit a chest x-ray (CXR) report to the Office of Health Services. Students who recently converted to positive TST or positive QFTB-Gold should be offered prophylactic treatment unless medically contraindicated to receive treatment. Student refusal of prophylactic treatment for LTBI must be indicated below.

Reason: _____

Latent Tuberculosis Infection (LTBI) Treatment Start Date: ____ / ____ / ____ End Date: ____ / ____ / ____

Health Practitioner Name: _____ Title: _____ License No.: _____

Address: _____ City _____ State _____ Zip _____

Office Phone No.: _____ - _____ - _____ Fax No.: _____ - _____ - _____

Examination Date: ____ / ____ / ____

Health Practitioner Signature _____

