Our Lady of Hope Catholic School
46633 Algonkian Parkway
Potomac Falls, VA 20165
(703) 433-6760
Fax (703) 433-6761

QUESTIONNAIRE TO ASSESS NEED FOR PPD TESTING

PATIENT NAME: _____

DATE OF BIRTH: _____

DATE: _____

Has a family history of TB or a TB positive contact. Yes ____ No ____
If yes, has the member been treated? Yes_____ No _____

Was born in Asia, Africa, Eastern Europe, Latin America or the Middle East. Yes ____ No ____
If yes, Where? _____
Did he/she get a BCG vaccine? Yes ____ No ____

Lives with people who have lived in Asia, Africa, Latin America, Yes ____ No ____
Eastern Europe or the Middle East.

Is HIV positive or lives with an HIV positive individual. Yes ____ No ____

Is adopted and no previous health history is known. Yes ____ No ____

Has been in a correctional facility in the past 5 years. Yes ____ No ____

Is exposed to institutionalized people (nursing homes, residential facilities, Yes ____ No ____
jail), HIV positive or homeless people, drug users or migrant farm workers.

Has a nanny or house keeper from Asia, Latin America, Eastern Europe or the Middle East. Yes ____ No ____
If yes, do you know her TB test results? Yes ____ No ____

Has traveled to Africa, Asia, Eastern Europe, Latin America, or Middle East. Yes ____ No ____

If yes, where and for how long? _____

OUR LADY OF HOPE CATHOLIC SCHOOL

REPORT OF TUBERCULOSIS SCREENING

Diocese of Arlington Office of Catholic School policies require School volunteers and contracted or auxiliary services personnel (i.e. janitors, lunchroom staff, etc.) who have regular and/or close contact with the students are required to provide verification of a negative tuberculosis screening. This report must be dated and signed by the examining physician, the physician's designee; the form must also identify the physician/physician practice with which the physician-designated screener is affiliated.

Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

[ ] Tuberculin Skin Test (TST): Date Given: _____ Date Read: _____
Results: _____mm Positive: _____ Negative: _____

[ ] Chest X-Ray: The individual has a history of a positive tuberculin skin test. The follow-up chest x-ray on _____ (date) at _____(location) shows no evidence of active tuberculosis. The individual has no current symptoms suggestive of active tuberculosis disease.

[ ] Treatment: The individual either is currently receiving or has recently completed medication for a tuberculosis infection. A chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

[ ] Based on the screening and or testing results, this individual is considered free of tuberculosis in communication form.

Signature/Title: _____ Date: _____
(MD/designee or Health Department Official)

Practice Name: _____ _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone Number: _____ Fax: _____