THE LEADER IN GLOBAL EDUCATION
FAIRLEIGH DICKINSON UNIVERSITY

STUDENT HEALTH SERVICES
Metropolitan Campus
1000 River Road, T-SU2-03
Teaneck, New Jersey 07666
Phone: (201) 692-2437
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POSITIVE TB TEST CHECKLIST

Name: _____
Last First FDU Student ID#

Date of Birth: _____/_____/_____ Phone: ( ) _____
Month Day Year

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1. **A. Positive Mantoux Test**

   Date Implanted: _____ Date Read: _____

   Size of Reaction: _____ (millimeters of Induration)

   B. QuantiFERON TB Gold or T-spot Test: Result_____ (MUST ATTACH LAB REPORT)

2. **Symptom Assessment for Pulmonary Tuberculosis** (*Check all TB- like symptoms that apply):*

   ☐Productive Cough of Undiagnosed Cause (more than 3 weeks in duration)
   ☐Coughing Up Blood (hemoptysis)
   ☐Unexplained Weight Loss (10 pounds or greater without dieting)
   ☐Night Sweats (regardless of room temperature)
   ☐Unexplained Loss of Appetite
   ☐Fever
   ☐Chills
   ☐Chest Pain
   ☐Very Easily Tired (fatigability)

   ☐*No TB-Like Symptoms Reported or Observed*

3. **Chest X-Ray (*Please attach radiologist's report of chest x-ray)***

   Date: _____

   Result: _____

4. **Chemoprophylaxis**

   Discussed on Date: _____

   Treatment recommended (*Circle One*): YES or NO

   If yes, record chemoprophylaxis treatment given:

   Name of Drug(s):_____

   Dosage: _____

   Date Initiated _____ Duration_____ Date Completed_____

5. **BCG:** Yes ☐ (date received_____) No ☐

Signature of Medical Provider: _____ **Date:** _____

Print Name: _____ **Phone Number:** _____

Address: _____

_____

OFFICE STAMP OR PROVIDER LICENSE NUMBER