Creighton UNIVERSITY

Student Health Services 402.280.2735
fax 402.280.1859

TUBERCULOSIS PROVIDER REVIEW

NAME _____ DATE _____

BIRTH DATE _____ NET ID _____

Positive TB Skin Test (PPD) Date: _____
Induration: _____ mm

Last Chest X-Ray Date: _____
Results: _____

INH Therapy YES or NO
Date Started: _____ End Date: _____

QuantiFERON Gold/Result _____

B/P _____ Temp _____

Pulse _____ Resp _____

HT _____ WT _____

MEDS _____

_____

_____

ALLERGIES _____

Please indicate symptoms 3 weeks or longer.

1. Chronic Cough YES _____ NO _____
2. Production of Sputum YES _____ NO _____
3. Unexplained Weight Loss YES _____ NO _____
4. Fever YES _____ NO _____
5. Fatigue / Tiredness YES _____ NO _____
6. Night Sweats YES _____ NO _____

EXAMINATION

	Normal	Abnormal	No exam
1 General			
2 Skin			
3 Lymph Nodes			
4 Neck/thyroid			
5 Respiratory			
6 Abdomen			
7 Cardio			

HPI/ROS: _____

_____

OBJECTIVE: _____

_____

ASSESSMENT: _____

_____

PLAN: CXR Required YES _____ NO _____ Results _____
Evidence of active disease YES _____ NO _____
Return to Clinic 1 year YES _____ NO _____

Signature of Clinician: _____ Date of Exam: _____