Annual Tuberculosis (TB) Screening

This form must be completed **AFTER MAY 1ST** (NO SOONER) and submitted by **JULY 31ST** at the latest.

Instructions for submission are on the Health Screening website: [https://fhs.mcmaster.ca/healthscreening/forms and submission.html](https://fhs.mcmaster.ca/healthscreening/forms and submission.html)

Health Screening Office contact: 905-525-9140 ext 22249, hrsadmin@mcmaster.ca

Student Name: ___________________________ Program: ___________________________

☐ PLEASE READ THE FOLLOWING FIRST: **TB Risk Assessment and TST Conversion**

**SECTION A. LAST TST NEGATIVE:** Do either of the following apply to you since your last negative TST?

☐ No ☐ Yes Travel outside Canada for one or more months which meets the criteria for TB testing.

☐ No ☐ Yes Notified by Occupational Health or Public Health as having significant exposure to an individual with active (infectious) TB disease not previously reported to the Health Screening Office.

Student signature: ___________________________________________ Date: ___________________________

“**No**” applies to BOTH questions: STOP HERE. Updated TST is NOT required by the Health Screening Office. **NOTE:** Some placement sites may require a more recent TST; students are responsible to be aware of the placement site requirements.

“**Yes**” applies to one or both questions: Provide documentation of TST dated eight or more weeks post-exposure.

☐ Post-exposure TST negative: STOP HERE. ☐ Post-exposure TST positive (TST conversion): **GO TO SECTION B.**

**SECTION B. LAST TST POSITIVE:**

☐ Positive TST or other positive TB history previously reported to the Health Screening Office:

Symptoms of TB disease? Symptoms include: Cough lasting three or more weeks; hemoptysis; shortness of breath; chest pain; fever; chills; night sweats; unexplained or involuntary weight loss.

☐ No: STOP HERE.

☐ Yes: You must withdraw from clinical activities and seek prompt medical attention. Letter from a physician required.

☐ Positive TST not previously reported to the Health Screening Office or positive post-exposure TST in Section A: You must withdraw from clinical activities and report the positive result to your Program Manager and the Health Screening Office immediately. Provide documentation of the positive TST and a chest x-ray report.

Symptoms of TB disease? ☐ No ☐ Yes: Letter from a physician required.

Student signature: ___________________________________________ Date: ___________________________

This section may be completed by a qualified health care professional (HCP) to document post-exposure TST or new positive TST:

<table>
<thead>
<tr>
<th>Date TST given (Year/Month/Day)</th>
<th>Date TST read (Year/Month/Day)</th>
<th>mm induration</th>
<th>Interpretation</th>
<th>HCP Initials</th>
</tr>
</thead>
</table>

HCP Name: ___________________________________________ Profession: ___________________________ Initials ____________

Signature: ___________________________________________ Date: ___________________________

Address/Telephone: ________________________________________________________________