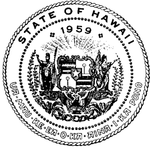


REQUIRED TB Form F: State of Hawai'i TB Clearance Form

Hawai'i State Department of Health
Tuberculosis Control Program

Patient Name	DOB	TB Screening Date

I have evaluated the individual named above using the process set out in the DOH TB Clearance Manual and determined that the individual does not have TB disease as defined in the Hawai'i Administrative Rules 11-164.2.

I. Screening for schools, child care facilities, or food handlers *(TB Document A,A.2 or E)*

☐ Negative TB risk assessment
☐ Negative test for TB infection: TST: mm, date read: ; or QFT date:
☐ Positive test for TB infection: TST: mm, date read: ; or QFT date: and negative chest X-ray (date:)

II. Initial Screening for Health Care Facilities or Residential Care Settings (*TB Document B, B.2, C, C.2)*

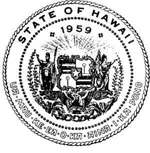
☐ Negative Risk Assessment: Children 1-17 yrs old, who are household members in adult residential care settings
Adults and Pediatric clients / patients living or working in a DOH licensed facility: ☐ Negative test for TB infection (2-step TST or QFT; or single TST/symptom screen plus negative CXR): TST #1: mm, date read: TST #2: mm, date read: **or** QFT date: Single TST: mm, date read: Symptoms Screen date: Negative chest X-ray date:
☐ New positive TB test: TST: mm; date read: or QFT date: Negative CXR date:
☐ Previous positive test for TB infection: ☐ negative symptoms screen, date: ☐ negative risk assessment, date: ☐ negative CXR within previous 12 months: Date of CXR:
☐ Previous positive test for TB infection, and negative CXR: Date of CXR:

III. Annual Screening for Health Care Facilities or Residential Care Settings (*TB Document D, D.2)*

☐ Negative risk assessment and negative symptom screen (Persons working in Health Care Facilities
☐ Negative test for TB infection: TST: mm, date read or QFT date:
☐ New positive test for TB infection: TST: mm, date read: or QFT date: and negative chest X-ray (date:)
☐ Previous positive test for TB infection and negative symptoms screen

Signature or Unique Stamp of Practitioner: ____
Printed Name of Practitioner (MD/DO/APRN/NP/PA): ____________________________
Healthcare Facility: ____
Address: ____
Phone Number: ______________________________________ Fax: _________________

This TB clearance provides a reasonable assurance that the individual listed on this form was free from tuberculosis disease at the time of the exam. This form does not imply any guarantee or protection from future tuberculosis risk for the individual listed.



TB Form G: State of Hawai'i TB Risk Assessment for Adults and Pediatric Persons

Hawai'i State Department of Health
Tuberculosis Control Program

1. Check for TB Risk Factor(s): * Refer to Document J for country TB case rates.

Being born in, living in, visiting (≥ three weeks) a country with a high TB case rate is a risk factor. Being visited by someone from a country with a high TB case rate is a risk factor.

- **If there are ANY risk factors, further TB testing (TST / IGRA / chest X-ray) is required for TB clearance.**
- **Form G is NOT a TB clearance. Please complete Form F to issue a TB clearance.**

Country of Birth: ____________________________ □ **has** □ **does not have** a high TB case rate. *

The United States, Japan, Canada, Australia, New Zealand, Western Europe (Great Britain, France, Spain, Portugal, Germany), Northern Europe (Norway, Sweden, Denmark) have low TB case rates.

a. <u>Initial Evaluation</u>: I □ **have not** □ **have** traveled to (or lived in) a foreign country for a total of three weeks or longer. **Name of foreign country (countries)**: ___________________

b. <u>Annual (follow-up) Evaluation</u>: Since my last TB clearance, I □ **have** □ **have not** traveled to (or lived in) a foreign country for a total of three weeks or longer.
Name of foreign country (countries)*: ___________________

Initial Evaluation: I □ **have not** □ **have** been in contact with someone with (infectious) TB disease.

Annual (follow-up) Evaluation: **Since my last TB evaluation**, I □ **have** □ **have not** been in contact with someone with (infectious) TB disease.

I □ **have** □ **do <u>not</u> have** **a health problem that affects my immune system,** e.g. *HIV/AIDS, chronic steroids (one month or longer), transplant recipient, cancer requiring radiation or chemotherapy.*

I □ **have** □ **do <u>not</u> have** **a medical treatment planned that may affect my immune system**, e.g. *treatment with TNF-alpha antagonist (e.g. Humira, Enbrel, Remicade), chemotherapy, chronic steroids (e.g. Prednisone for one month or longer).*

a. <u>Initial evaluation</u>: **I** □ **have** □ **have not** lived with someone who was born in a foreign country.
Name of foreign country *: ______________________________

b. <u>Annual (follow-up) evaluation</u>: Since my last TB evaluation -

1) I □ **have** □ **have not** lived with someone who was born in a foreign country.
Name of foreign country *: ___________________________

2) One or more people □ **did <u>not</u> visit my home** for a total of three weeks or longer.
One or more people □ **did visit my home** for a total of three weeks or longer and,
□ **was/were** □ **was/were NOT** from a foreign country *.
Name of foreign country *: ______________________

Medical Staff reviewing symptom screen and risk factors (RN/LPN/MD/DO/APRN/NP/PA): **Assessment Date:**	**Client/Patient's Name and DOB:** **Name and Relationship of Person Providing Information (if not the above-named person):**