TUBERCULOSIS SCREENING
Annual form only required after positive PPD or bloodwork
(This form should be completed by your health care provider)

Name: ___________________________ Date: ________________

PPD Date: ___________ PPD Result: _________________mm

Quantiferon Gold or T-Spot Date: _______________ Result ____________mm

If PPD/Quantiferon Gold or T-Spot Positive:
1) Date of positive testing: ________________________________

2) Treatment: ______________________ Dates: ______________________

3) Chest X-Ray: ______________________________ Date: ________________

Results within past 24 months

Screening Practitioner’s Name (Print) ___________________________ Date

Screening Practitioner’s Signature ___________________________

Are you currently experiencing any of the following symptoms?

- Fever
- Cough
- Recent Weight Loss
- Hemoptysis

Yes ☐ No ☐

Applicant’s Signature __________________________

**PLEASE UPLOAD COMPLETED FORM TO: THE STUDENT HEALTH SUBMISSION PORTAL.
*Go to the LSU Health New Orleans Homepage, click MYLSUHSC>Self Service>Academic Self-Service, you must login and continue to upload your completed form.

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