Nevada Tuberculosis Testing Record:

Healthcare Personnel/Employee

Prior to employment the healthcare personnel/employee must complete a baseline tuberculosis (TB) test, either the two-step TB skin test (TST) or an approved TB screening blood test (IGRA: QFT or T-spot) **NAC 441A.375**. If the individual has a valid documented allergic/adverse reaction to the TB skin test, they need to instead be offered a blood test.

Baseline (preplacement) TB screening should include an Individual TB Risk Assessment, per updated CDC recommendations for Healthcare personnel TB testing (MMWR, 2019, https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6819a3-H.pdf).

Counseling and preventive treatment is highly recommended and must be offered to a person with a positive TB screening test **(NAC 441A.375; 7, formerly 5).**

If the healthcare personnel/employee has a previously documented positive TB screening test or a documented diagnosis of TB or Latent Tuberculosis Infection (LTBI), regardless if treated or untreated, the facility should perform annual TB screening activities that includes the use of the following form instead of the TST or IGRA: *Nevada Tuberculosis Signs and Symptoms Questionnaire*. A repeat chest X-ray is only required if symptoms develop or it is recommended by a clinician (p. 51, *MMWR* , 2005, www.cdc.gov/mmwr/pdf/rr/rr5417.pdf). A chest X-ray should not be used in place of the *Signs and Symptoms Questionnaire*.

A healthcare personnel/employee who is a suspect case of TB (tests positive for Tuberculosis or has tested positive in the past) may not begin work until he/she is deemed non-infectious, pursuant to **NAC 441A.360** and **NRS 441A.120.**

Healthcare personnel/employees are not required by law to be treated for LTBI.

I understand the above information and consent to a two-step TB skin test or a blood test and any treatment and care as required by law. By doing this, I am complying with **NAC 441A.375** which mandates that a new healthcare personnel/employee in a healthcare facility must have a physical examination before initial employment and a completed two-step TST or IGRA TB test.

Name: _____ Date of Birth: _____
(Please Print)

Healthcare Personnel/Employee's Signature: _____ Date: _____

Authorized Medical Screener's Signature: _____ Date: _____

Authorized Medical Screener's Name: _____

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Date Test Given (mm/dd/yyyy): _____ Site: ☐ Left Arm ☐ Right Arm Date Test Read (mm/dd/yyyy): _____ Interpretation: ☐ Negative ☐ Positive	Test Given by (Name of Individual & Facility): _____ Test Read by (Name of Individual & Facility): _____ Measurement of Induration: (mm) _____
SECOND STEP OF THE TWO-STEP TB SKIN TEST:	
Date Test Given (mm/dd/yyyy): _____ Site: ☐ Left Arm ☐ Right Arm Date Test Read (mm/dd/yyyy): _____ Interpretation: ☐ Negative ☐ Positive	Test Given by (Name of Individual & Facility): _____ Test Read by (Name of Individual & Facility): _____ Measurement of Induration: (mm) _____ Induration Guide: www.cdc.gov/tb/publications/LTBI/diagnosis.htm
BLOOD TEST (IGRA):	
Type of IGRA (T-spot or QFT): _____ Date Blood Drawn (mm/dd/yyyy): _____ Blood Drawn by (Name of Individual&Facility): _____	Date Results Reported to Facility-by Lab or HCW (mm/dd/yyyy): _____ Results Reported to (Department Name and Individual): _____ Interpretation: ☐ Negative ☐ Positive
CHEST X-RAY (CXR):	
(The CXR should only be performed if the individual has a positive skin/blood test. The CXR is used to rule out active TB disease.) **NOTE: If active TB is suspected do CXR – do not wait for TST result, may be false negative**	
Date of CXR (mm/dd/yyyy): _____	Interpretation: ☐ Normal ☐ Abnormal If Abnormal, Date Referred for Medical Evaluation (mm/dd/yyyy): _____
LTBI OR ACTIVE TB DIAGNOSIS:	
LTBI: Date resident/patient was referred for and provided LTBI education/information by healthcare facility. (Report sent to local health department pursuant to NAC 441A.350 via Nevada's *Confidential Report Form-Latent Tuberculosis Infection*, see pages 50-51, Appendix B, of the *Healthcare Facilities TB Screening Manual*). (mm/dd/yyyy): _____ Active TB: Date local health district/TB clinic was notified of suspect or active TB case pursuant to NAC 441A. 325 and NAC 441A. 350. (Report sent to local health department via Nevada's *Confidential Morbidity Report*, see pages 52-53, Appendix C, of the *Healthcare Facilities TB Screening Manual*). (mm/dd/yyyy): _____ **Last Name:_____ First Name:_____ DOB: _____**	