University Health Services
150 Infirmary Way, Amherst, MA 01003-9288
University of Massachusetts Amherst

Tuberculosis Questionnaire

1. Complete this form with your licensed medical provider.
2. Login to https://umass.medicatconnect.com (choose “I have a UMass NetID” to login).
3. Navigate to "1. Action Items for UHS Patients & UMass Students". Click "Get Started". Click "Uploads". Upload a photo or scan of this form and any supporting documents.

Student Last Name: **First Name:** **Middle Name:**

_____

Date of Birth (mm/dd/yyyy) **SPIRE ID Number** **Semester Start (check one)**

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TUBERCULOSIS QUESTIONNAIRE

1. Have you worked or lived with someone with active TB (or will you prior to your arrival in the US)?	☐ Yes ☐ No	If yes, explain:
2. Were you born in, lived in, or have you traveled for more than 1 month to any of the high-risk countries found here: **umass.edu/uhs/TB**	☐ Yes ☐ No	If yes, explain:
3. Have you ever tested positive for TB or completed 3-9 months of medication to prevent active TB? (i.e. isoniazid)	☐ Yes ☐ No	If yes, explain:

Instructions	• If you answered **no to all questions** above, you do not need to complete this form. • If you answered **yes to questions 1 OR 2** above, a TB skin test or IGRA blood test must be completed no more than six months prior to the semester start date. Testing is available at UMass. • If you answered **yes to question 3 above** and have ever had a positive TB test in the past, do not repeat a TB test; fill out the Positive TB Test History section below.		
TB Skin Test	Date Given (mm/dd/yyyy) __ / __ / ____	Result: ☐ Positive ☐ Negative ☐ Indeterminate	
OR	**IGRA Blood Test recommended for those with historical immunization with BCG vaccine.**		
IGRA Blood Test	Date Given (mm/dd/yyyy) __ / __ / ____	Result: ☐ Positive ☐ Negative ☐ Indeterminate	
Positive TB Test History	Please complete this section if you have ever had a positive TB skin test and/or have ever received treatment for TB.		
Chest X-Ray	Date Given (mm/dd/yyyy) __ / __ / ____	Result: ☐ Normal ☐ Abnormal Describe:	
Clinical Evaluation	Date of Appointment (mm/dd/yyyy) __ / __ / ____	Result: ☐ Normal ☐ Abnormal Describe:	
Treatment	Date of Treatment (mm/dd/yyyy) __ / __ / ____	☐ **Yes** If yes, drug, dose & frequency:	☐ **No** If no, reason why treatment not done:

LICENSED MEDICAL PROVIDER (MD, DO, PA, NP, RN OR MBBS) VERIFICATION (REQUIRED):

_____

Provider Printed Name *Provider Signature/Credentials*

Provider Phone: _____ Date: _____