



TB Document F: State of Hawaii TB Clearance Form

Hawaii 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 dated 2/10/17 and determined that the individual does not have TB disease as defined in section 11-164.2-2, Hawaii Administrative Rules.

Screening for schools, child care facilities or food handlers <i>(TB Document A or E)</i>
<input type="checkbox"/> Negative TB risk assessment
<input type="checkbox"/> Negative test for TB infection
<input type="checkbox"/> Positive test for TB infection, and negative chest X-ray

Initial Screening for health care facilities or residential care settings <i>(TB Document B or C)</i>
<input type="checkbox"/> Negative test for TB infection (2-step)
<input type="checkbox"/> New positive test for TB infection, and negative chest X-ray
<input type="checkbox"/> Previous positive test for TB infection, negative CXR within previous 12 months, and negative symptom screen
<input type="checkbox"/> Previous positive test for TB infection, and negative CXR

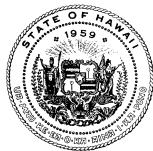
Annual Screening for Health care facilities or residential care settings <i>(TB Document D)</i>
<input type="checkbox"/> Negative test for TB infection
<input type="checkbox"/> New positive test for TB infection, and negative chest X-ray
<input type="checkbox"/> Previous positive test for TB infection, and negative symptoms screen
<input type="checkbox"/> Previous positive test for TB infection, and negative CXR

Signature or Unique Stamp of Practitioner: _____

Printed Name of Practitioner: _____

Healthcare Facility: _____

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 Document G: State of Hawaii TB Risk Assessment for Adults and Children
 Hawaii State Department of Health
 Tuberculosis Control Program

1. Check for TB symptoms

- If there are significant TB symptoms, then further testing (including a chest x-ray) is required for TB clearance.
- If significant symptoms are absent, proceed to TB Risk Factor questions.

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does this person have significant TB symptoms? Significant symptoms include <u>cough for 3 weeks or more</u>, plus at least one of the following:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Coughing up blood</td> <td style="width: 33%;"><input type="checkbox"/> Fever</td> <td style="width: 33%;"><input type="checkbox"/> Night sweats</td> </tr> <tr> <td><input type="checkbox"/> Unexplained weight loss</td> <td><input type="checkbox"/> Unusual weakness</td> <td><input type="checkbox"/> Fatigue</td> </tr> </table>	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Fever	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Unusual weakness	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Fever	<input type="checkbox"/> Night sweats					
<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Unusual weakness	<input type="checkbox"/> Fatigue					

2. Check for TB Risk Factors

- If any “Yes” box below is checked, then TB testing is required for TB clearance
- If all boxes below are checked “No”, then TB clearance can be issued without testing

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Was this person born in a country with an elevated TB rate? Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Has this person traveled to (or lived in) a country with an elevated TB rate for four weeks or longer?</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>At any time has this person been in contact with someone with <i>infectious TB disease</i>? (Do not check “Yes” if exposed only to someone with latent TB)</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the individual have a health problem that affects the immune system, or is medical treatment planned that may affect the immune system? (Includes HIV/AIDS, organ transplant recipient, treatment with TNF-alpha antagonist, or steroid medication for a month or longer)</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>For persons under age 16 only: Is someone in the child’s household from a country with an elevated TB rate?</p>

<p>Provider Name with Licensure/Degree:</p> <p>Assessment Date:</p>	<p>Person's Name and DOB:</p> <p>Name and Relationship of Person Providing Information (if not the above-named person):</p>
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