University Health Services
2751 O'Varsity Way, 3rd Floor, Room 335
Cincinnati, Ohio 45221
Phone: 513-556-2564, Fax: 513-556-1337
UHSTracking@ucmail.uc.edu

# University Health Services Registration Form

| | |
|---|---|
| **First Name** | |
| **Middle Name** | |
| **Last Name** | |
| **Gender** | |
| **Date of Birth (MM/DD/YYYY)** | |
| **Emergency Contact** | **Name:** |
| | **Phone #:** |
| | **Relationship to you:** |
| **US Address (if known)** | |
| **US Phone Number (if known)** | |
| **Email Address** | |
| **Language** | |
| **Need Interpreter?** | ☐ Yes ☐ No |
| **Hearing Impaired?** | ☐ Yes ☐ No |
| **Visually Impaired?** | ☐ Yes ☐ No |
| **Marital Status** | ☐ Single ☐ Married |
| **Ethnic Group** | ☐ Hispanic ☐ Latino ☐ Not Hispanic or Latino |
| **Race/Nationality** | |
| **M#** | |
| **Semester** | |

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# University of Cincinnati Tuberculosis Risk Assessment

Please have your licensed medical provider review and complete the following form, evaluating history and risk factors for Tuberculosis.

| | | | |
|---|---|---|---|
| **First Name** | | **Last Name** | |
| **M#** | | **DOB** | |
| **UC Email** | | **Semester/Year** | |

| | |
|---|---|
| Date of Arrival to USA | |
| Birth Country | |
| Have you ever had close contact with anyone known or suspected of having **active TB disease?** | ☐ No ☐ Yes<br>If Yes, list most recent contact: |
| Have you ever been a resident, volunteer, and/or employee of a high-risk congregate setting such as prisons, long term care, homeless shelter? | ☐ No ☐ Yes |
| Have you ever been a volunteer or health care worker who served people that are increased risk for active TB disease? | ☐ No ☐ Yes |
| Have you ever been a member of any of the following high-risk groups: medically underserved, lower income, drug/alcohol abuser? | ☐ No ☐ Yes |
| Do you have a weakened immune system (i.e. human immunodeficiency virus (HIV) infection, long-term use of prednisone (greater than 2 weeks), and/or other immune-suppressing drugs? | ☐ No ☐ Yes |
| Do you have rheumatoid arthritis, Crohn's disease, and/or other conditions which are treated with immune suppressing drugs (i.e. Remicade, Enbrel, or Humira)? | ☐ No ☐ Yes |
| Have you ever received the BCG vaccine (usually given as an infant or child, and leaves a scar on the upper arm)? | ☐ No ☐ Yes ☐ Unknown |
| Do you have a history of Tuberculosis? | ☐ No ☐ Yes |
| Have you ever been treated for Tuberculosis? | ☐ No ☐ Yes<br>If Yes, list date and treatment: |
| Do you have a history of a positive (abnormal) TB skin or blood test? | ☐ No ☐ Yes<br>If Yes, list type (skin or blood): |
| If you have completed lab or x-ray testing for Tuberculosis, was the testing done outside of the United States? | ☐ No ☐ Yes |
| Have you received any vaccines in the last 30 days? | ☐ No ☐ Yes<br>If Yes, list here: |
| **Circle any of the countries or territories you have lived in or spent at least 2 weeks in (*see other side of page)** | |

***NOTE TO PROVIDER:*** If the patient has answered **YES** to any of the above questions or has visited a high-risk country, an IGRA blood test in the past three months is required. The student must return the completed and signed questionnaire AND proof of an IGRA blood test. Patient must complete the UC Clinical Assessment for Tuberculosis form. If IGRA is positive, the student must also have a chest xray done.

**The above health statement is accurate to the best of my knowledge.**

| | | | |
|---|---|---|---|
| Student Signature | | Date | |

**Screening administered by licensed healthcare professional:**

| | | | |
|---|---|---|---|
| Printed name and location: | | | |
| Signature | | Date | |

## *High Risk Countries

| | | | |
|---|---|---|---|
| Afghanistan | Djibouti | Madagascar | Rwanda |
| Algeria | Dominican Republic | Malawi | Sao Tome and Principe |
| Angola | Ecuador | Malaysia | Senegal |
| Anguilla | El Salvador | Maldives | Sierra Leone |
| Argentina | Equatorial Guinea | Mali | Singapore |
| Armenia | Eritrea | Marshall Islands | Solomon Islands |
| Azerbaijan | Eswatini | Mauritania | Somalia |
| Bangladesh | Ethiopia | Mexico | South Africa |
| Belarus | Fiji | Micronesia | South Sudan |
| Belize | Gabon | Moldova | Sri Lanka |
| Benin | Gambia | Mongolia | Sudan |
| Bhutan | Georgia | Morocco | Suriname |
| Bolivia | Ghana | Mozambique | Tajikistan |
| Bosnia and Herzegovina | Greenland | Myanmar | Tanzania |
| Botswana | Guam | Namibia | Thailand |
| Brazil | Guatemala | Nauru | Timor-Leste |
| Brunei Darussalam | Guinea | Nepal | Togo |
| Burkina Faso | Guinea-Bissau | Nicaragua | Tunisia |
| Burundi | Guyana | Niger | Turkmenistan |
| Cabo Verde | Haiti | Nigeria | Tuvalu |
| Cambodia | Honduras | Niue | Uganda |
| Cameroon | India | Northern Mariana Islands | Ukraine |
| Central African Republic | Indonesia | Pakistan | Uruguay |
| Chad | Iraq | Palau | Uzbekistan |
| China | Kazakhstan | Panama | Vanuatu |
| China, Hong Kong SAR | Kenya | Papua New Guinea | Venezuela |
| China, Macao SAR | Kiribati | Paraguay | Vietnam |
| Colombia | Kyrgyz Republic | Peru | Yemen |
| Comoros | Lao People's Dem. Rep. | Philippines | Zambia |
| Congo | Lesotho | Qatar | Zimbabwe |
| Cote d'Ivoire | Liberia | Rep. of Korea (S. Korea) | |
| Dem. Rep. of Korea | Libya | Romania | |
| Dem. Rep. of Congo | Lithuania | Russian Federation | |

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# University of Cincinnati Clinical Assessment for Tuberculosis

Please have your licensed medical provider review and complete the following form, evaluating symptoms and past history with Tuberculosis.

| | | | |
|---|---|---|---|
| **First Name** | | **Last Name** | |
| **M#** | | **DOB** | |
| **UC Email** | | **Phone #** | |

## *TB Symptom Screening*

**Does the student have signs or symptoms of active pulmonary tuberculosis disease? ☐ Yes ☐ No**

If yes, please check all that apply below:

☐ Cough (especially if lasting for 3 weeks or longer) with our without sputum production
☐ Coughing up blood (hemoptysis)
☐ Chest pain
☐ Loss of appetite
☐ Unexplained weight loss
☐ Night sweats
☐ Fever

If yes to any of the above, ***in addition to an IGRA blood test,*** proceed with evaluation to exclude active tuberculosis disease including chest x-ray (PA and lateral) and sputum evaluation as indicated.

## *TB Testing History*

**IGRA blood test within 3 months prior to the start of classes at the University of Cincinnati is required. If you have more than one IGRA blood test or chest x-ray, please list them below.**

| | Date Obtained | Method | Result | Lab Report Attached (*required*) |
|---|---|---|---|---|
| **Interferon Gamma Release Assay (IGRA)** T-spot/QuantiFERON TB Gold blood tests for tuberculosis | | ☐ QFT ☐ T-Spot | ☐ Negative ☐ Positive ☐ Indeterminate | ☐ |
| | | ☐ QFT ☐ T-Spot | ☐ Negative ☐ Positive ☐ Indeterminate | ☐ |
| | | ☐ QFT ☐ T-Spot | ☐ Negative ☐ Positive ☐ Indeterminate | ☐ |

| | Date Obtained | Result | Chest x-ray Report Attached (*required*) |
|---|---|---|---|
| **Chest x-ray** Required if history of positive IGRA | | ☐ Normal ☐ Abnormal | ☐ |
| | | ☐ Normal ☐ Abnormal | ☐ |
| | | ☐ Normal ☐ Abnormal | ☐ |

| First Name | | Last Name | |
|---|---|---|---|
| M# | | DOB | |
| UC Email | | Phone # | |

## *TB Treatment History*

**Please disregard this section if you have never been treated for latent or active Tuberculosis.**

| | Medication Name(s) | Start Date | Stop Date | Dose | Dosing Frequency | Directly Observed Therapy (DOT) |
|---|---|---|---|---|---|---|
| Treatment for latent Tuberculosis infection | | | | | | ☐ |
| | | | | | | ☐ |
| | | | | | | ☐ |
| | | | | | | ☐ |

| | Medication Name(s) | Start Date | Stop Date | Dose | Dosing Frequency | Directly Observed Therapy (DOT) |
|---|---|---|---|---|---|---|
| Treatment for active Tuberculosis disease | | | | | | ☐ |
| | | | | | | ☐ |
| | | | | | | ☐ |
| | | | | | | ☐ |
| | | | | | | ☐ |
| | Disease Location | ☐ Lung ☐ Outside of Lung | | | | |

## *MUST BE SIGNED BY A LICENSED HEALTHCARE PROFESSIONAL:*

| Healthcare Professional Signature | | Date |
|---|---|---|
| Printed Name | | Office Stamp |
| Professional License # | | |
| Title | | |
| Address | | |

**Please email completed forms and test results to UHSTracking@ucmail.uc.edu. DO NOT upload to Bearcats Health app.**