Part 2-2. Clinical Assessment by Physicain or Health Care Provider 医師が記入すること

To Physician or Health Care Providers; please review and verify the information in Part2-1 "Tuberculosis (TB) Screening Questionnaire";

Name of Student (Family, Middle, Given) 氏名 Takeshi Tanaka

Is there any YES to any of the questions in Part 2-1?

☐ **NO**
☑ **YES**

If **NO**, no further examination is required.
You may finish with your signature at the bottom of this page.

If YES, please complete the following TB screening examination.

Does the student have a history of BCG vaccination? **Yes** _____ **No** ✔

If Yes, IGRA should be performed instead of TST.
If there is no history of BCG, either TST or IGRA is accepted.
Instead of performing TST or IGRA, a recent * result of Chest X-ray is also accepted. (*Within 2 months)

1. Tuberculin Skin Test (TST)
(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)

Date Given: Oct / 01 / 2018 (M / D / Y) Date Read: Oct / 16 / 2018 (M / D / Y)

Result: 0 mm of induration **Interpretation: positive____ negative✔

2. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (M / D / Y) (specify the method) QFT-GIT T-Spot other_____

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

3. If TST or IGRA is positive; chest X-ray is REQUIRED to exclude active TB.

Chest x-ray:

Date of chest x-ray: ____/____/____ (M / D / Y) Result: normal____ abnormal_____

Dr. James Bond

Print name of Physician / Health Care Provider

James Bond

Signature of Physician / Health Care Provider

stamp stamp
James Bond Clinic
Hospital Hospital

Official Stamp (Name) of Institution (or Clinic)

Dec. 01, 2018

Date (M, D, Y)