Barren River
DISTRICT HEALTH DEPARTMENT
Barren, Butler, Edmonson, Hart, Logan, Metcalfe, Simpson, and Warren Counties

POSITIVE TUBERCULOSIS TESTING REPORT TO LOCAL HEALTH DEPARTMENT

In accordance with 902KAR20:200: TB testing for residents in long term care settings

"Section 10. Reporting to Local Health Departments.

1) A long term health setting's administrator or the administrator's designee shall report a resident identified with one (1) of the following to the local health department having jurisdiction within one (1) business day upon becoming known:

a) A TST conversion or BAMT conversion on serial testing or identified in a contact investigation;
b) A chest x-ray which is suspicious for TB disease;
c) A sputum smear positive for acid-fast bacilli;
d) A rapid laboratory test positive for Mycobacterium tuberculosis DNA or RNA, such as Mycobacterium tuberculosis positive NAA tests or PCR tests;
e) Sputum cultures positive for mycobacterium Tuberculosis; or
f) The initiation of multi drug antituberculosis treatment for a resident.

2) A long term care setting's administrator or administrator's designee shall report a resident identified with one (1) of the following to the local health department having jurisdiction within five (5) business days upon becoming known:

a) A TST of ten (10) millimeters or more induration at the time of admission if the TST result was interpreted as positive.
b) A TST result of five (5) millimeters to nine (9) millimeters of induration at the time of admission for a resident who has a medical reason as described in Section 3(3) of this administrative regulation for his or her TST result to be interpreted as positive; or
c) C) A positive BAMT at the time of admission."

TB Control Program
Barren River District Health Department
PO Box 1157
Bowling Green, KY 42102-1157
Phone: (270) 781-8039 Ext. 190 Fax: (270) 796-8946

Name of Facility: _____

Address_____ # of Beds _____

Name of Resident: _____ Physician's Name_____
D.O.B._____/_____/_____ S.S. #_____-_____-_____

PPD Date Given_____/_____/_____ Date Read_____/_____/_____ Result_____mm (Tubersol or Aplisol)

Was this a "2-step" PPD? Yes _____No_____

IGRA/BAMT TYPE_____ Date drawn_____/_____/_____Result_____

New Converter (negative last year/positive now) Yes_____ No_____

New Admission: Yes_____No_____ If new admission, received from_____

Signs/Symptoms of Tuberculosis

a. Productive cough Yes ___ No ___
b. Fever Yes ___ No ___
c. Weight loss Yes ___ No ___
d. Night sweats Yes ___ No ___
e. Fatigue Yes ___ No ___
f. Hoarseness Yes ___ No ___
g. Chest Pain Yes ___ No ___

Medical evaluation _____Yes_____No Chest X-ray: Date _____/_____/_____ (attach copy of report)

HIV testing _____Yes_____ Date _____ Result_____

Sputums to State Laboratory x 3 (Dates) 1. ____/____/____ 2. ____/____/____ 3. ____/____/____

Treatment, follow-up, and/or recommendations by Physician: _____

_____

Signature _____ Date _____/_____/_____