

**In accordance with 902KAR20:205: TB testing for Health Care Workers.**

“Section 10. Reporting to Local Health Departments. “

- 1) A health facility’s administrator or the administrator’s designee shall report a health care worker identified with one (1) of the following to the local health department having jurisdiction within one (1) business day of 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) A sputum culture positive for Mycobacterium tuberculosis; or
  - f) The initiation of multi- drug antituberculosis treatment for active TB disease in a health care worker
- 2) A health facility’s administrator or the administrator’s designee shall report a health care worker identified with one(1) of the following to the local health department having jurisdiction within five (5) business days of becoming known:
- a) A TST of ten (10) millimeters or more induration at the time of initial employment at the facility if the TST result was interpreted as positive.
  - b) A TST result of five (5) or more millimeters of induration for a health care worker at the time of initial employment who has a medical reason as described in Section 4 (3) of this administrative regulation for the TST result to be interpreted as positive; or
  - c) A positive BAMT at the time of initial employment.”

**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 Employee: \_\_\_\_\_ 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 \_\_\_\_\_

**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 \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_ Result \_\_\_\_\_

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

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

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_