



U.S. Department of State
CHEST X-RAY AND CLASSIFICATION WORKSHEET

OMB No. 1405-0113
EXPIRATION DATE: 1/31/2004
ESTIMATED BURDEN: 45minutes
(See Page 2 – Back of Form)

For Use with DS-2053 Complete Sections 1 through 5, As Applicable

Name (last, First, MI)		Age																
Birth Date (mm-dd-yyyy)	Passport Number	Alien (case) Number																
1. Chest X-Ray Needed (mark all that apply) <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> History of tuberculosis (TB) disease <input type="checkbox"/> Contact with TB patient</div><div><input type="checkbox"/> TB signs or symptoms <input type="checkbox"/> Adult (with or without any of the other)</div></div> <p>(if child does not have any of above, stop here)</p>																		
2. Chest X-Ray Findings <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Normal findings <input type="checkbox"/> Abnormal finding (indicate findings and interpretation, check all that apply, and any other in table below)</div><div>Date Chest X-Ray taken (mm-dd-yyyy) _____</div></div> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"><thead><tr><th style="width: 33%; padding: 5px;"><input type="checkbox"/> Can suggest ACTIVE TB (Need smears)</th><th style="width: 33%; padding: 5px;"><input type="checkbox"/> Can suggest INACTIVE TB (Need smears if symptomatic)</th><th style="width: 33%; padding: 5px;"><input type="checkbox"/> OTHER X-ray findings</th></tr></thead><tbody><tr><td style="vertical-align: top; padding: 5px;"><input type="checkbox"/> Infiltration or consolidation <input type="checkbox"/> Any cavitary lesion <input type="checkbox"/> Nodule with poorly defined margins (such as tuberculoma) <input type="checkbox"/> Pleural effusion <input type="checkbox"/> Hilar/Mediastinal adenopathy <input type="checkbox"/> Linear, interstitial markings (children only) <input type="checkbox"/> Other (such as miliary findings)</td><td style="vertical-align: top; padding: 5px;"><input type="checkbox"/> Discrete fibrotic scar or linear opacity <input type="checkbox"/> Discrete nodule(s) without calcification <input type="checkbox"/> discrete fibrotic scar with volume loss or retraction <input type="checkbox"/> Discrete nodule(s) with volume loss or retraction <input type="checkbox"/> Other (such as bronchiectasis)</td><td style="vertical-align: top; padding: 5px;"><input type="checkbox"/> Follow-up needed <div style="margin-left: 20px;"><input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Cardiac <input type="checkbox"/> Pulmonary <input type="checkbox"/> Other</div> <input type="checkbox"/> No follow –up needed for Pleural thickening, diaphragmatic tenting, Blunting costophrenic angle, solitary calcified nodule or granuloma or minor musculoskeletal or cardiac finding</td></tr></tbody></table> <div style="margin-top: 10px;">Remarks _____ _____ _____</div>			<input type="checkbox"/> Can suggest ACTIVE TB (Need smears)	<input type="checkbox"/> Can suggest INACTIVE TB (Need smears if symptomatic)	<input type="checkbox"/> OTHER X-ray findings	<input type="checkbox"/> Infiltration or consolidation <input type="checkbox"/> Any cavitary lesion <input type="checkbox"/> Nodule with poorly defined margins (such as tuberculoma) <input type="checkbox"/> Pleural effusion <input type="checkbox"/> Hilar/Mediastinal adenopathy <input type="checkbox"/> Linear, interstitial markings (children only) <input type="checkbox"/> Other (such as miliary findings)	<input type="checkbox"/> Discrete fibrotic scar or linear opacity <input type="checkbox"/> Discrete nodule(s) without calcification <input type="checkbox"/> discrete fibrotic scar with volume loss or retraction <input type="checkbox"/> Discrete nodule(s) with volume loss or retraction <input type="checkbox"/> Other (such as bronchiectasis)	<input type="checkbox"/> Follow-up needed <div style="margin-left: 20px;"><input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Cardiac <input type="checkbox"/> Pulmonary <input type="checkbox"/> Other</div> <input type="checkbox"/> No follow –up needed for Pleural thickening, diaphragmatic tenting, Blunting costophrenic angle, solitary calcified nodule or granuloma or minor musculoskeletal or cardiac finding										
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3. Sputum smears <div style="display: flex; justify-content: space-between; margin-top: 10px;"><div><input type="checkbox"/> No, applicant has no signs or symptoms of TB and: <input type="checkbox"/> Yes, applicant has (mark all that apply)</div><div><input type="checkbox"/> X-ray suggests INACTIVE TB, this is a Class B2/TB <input type="checkbox"/> OTHER X-ray findings suggest follow-up needed after arrival, this is B Other <input type="checkbox"/> OTHER X-ray findings suggest no follow-up needed, this is No Class <input type="checkbox"/> X-ray Normal, this is No Class</div></div> <div style="margin-top: 10px;"><table style="width:100%;"><tr><td style="width: 50%;"></td><td style="width: 10%; text-align: center;">Positive</td><td style="width: 10%; text-align: center;">Negative</td><td style="width: 30%; text-align: center;">Dates obtained (mm-dd-yyyy)</td></tr><tr><td><input type="checkbox"/> Signs or symptom of TB present, See Section 1</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr><tr><td><input type="checkbox"/> X-ray suggests ACTIVE TB, See Section 2</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr><tr><td></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr></table></div> <div style="display: flex; margin-top: 10px;"><div style="width: 35%; padding-right: 10px;">Sputum smear results and X-ray findings: At least one smear result POSITIVE and <input type="checkbox"/> Any chest X-ray finding, this is Class A/TB (Normal or Abnormal findings)</div><div>Three smear results NEGATIVE and <input type="checkbox"/> X-ray Normal with <input type="checkbox"/> Signs of symptoms resolved, this is No Class <input type="checkbox"/> Signs of symptoms suggest follow-up needed after arrival, this is B Other <input type="checkbox"/> X-ray suggests ACTIVE or INACTIVE TB, this is Class B1/TB <input type="checkbox"/> OTHER X-ray findings suggest follow-up needed after arrival, this is Class B Other</div></div>				Positive	Negative	Dates obtained (mm-dd-yyyy)	<input type="checkbox"/> Signs or symptom of TB present, See Section 1	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> X-ray suggests ACTIVE TB, See Section 2	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>	_____
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<input type="checkbox"/> X-ray suggests ACTIVE TB, See Section 2	<input type="checkbox"/>	<input type="checkbox"/>	_____															
	<input type="checkbox"/>	<input type="checkbox"/>	_____															
4. <input type="checkbox"/> No Class <input type="checkbox"/> Class A/TB <input type="checkbox"/> Class B1/TB <input type="checkbox"/> Class B2/TB <input type="checkbox"/> Class B Other, follow-up needed																		
5. Follow-up Needed After Arrival <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, for <input type="checkbox"/> Not TB condition <input type="checkbox"/> TB condition. (If yes, specify condition below and on DS-2053; include additional tests, and therapy used with start and stop dates and any changes) Remark _____ _____ _____																		

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 45 minutes per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. Persons are not required to provide this information in the absence of a valid OMB approval number. Send comments on the accuracy of this estimate of burden and recommendations for reducing it to: Department of State (A/RPS/DIR) Washington, DC 20520-1849.

We ask for information on this form, in the case of applicants for immigrant visas, to determine medical eligibility under INA Sections 212 (a) and 221 (d), and, in the case of refugees, as required under INA Section 412(b)(4) and (5). If an immigrant visa is issued or refugee status granted, you will convey this form to the INS for disclosure to the Center for Disease Control and the US Public Health Service. Failure to provide this information may delay or prevent the processing of your case. If an immigrant visa is not issued or refugee status is not granted, this form will be treated as confidential under INA Section 222(f).