TB Screening Form

Health Care Employee TB Screening Assessment Form
Screening for active/contagious Pulmonary Tuberculosis

1. Name_____

2. Are you from or have you lived for two or more months in Africa, Asia, Central or South America, or Eastern Europe? _____ (If yes, list country(s) and date(s):

_____

3. Have you had a Tuberculosis Skin Test before? _____
if yes, attach results (if possible) or provide further information _____

_____

4. Have you been exposed to a person with known active Tuberculosis since your last TB screening test? _____

5. Do you work or volunteer in any of the following facilities:

□ Prison □ Homeless Shelter □ AIDS outpatient or inpatient facility □None

6. Have you ever been diagnosed with a chronic medical condition or been treated with medication that has resulted in significant impairment of your immune system? □ YES □ NO

7. Do you currently have any of the following symptoms: □ NONE or
(check all that apply)

□ Cough for 3 or more weeks □Cough productive of sputum
□ Coughing up blood □ Chest pain
□ Night Sweats □ Excessive fatigue or weakness
□ Unexplained weight loss □ Unexplained loss of appetite
□ Respiratory difficulty □ Unexplained fever or chills for more than 7 days

Signature:_____ Date:_____

6. I certify that _____has been evaluated and was found to exhibit no evidence for active pulmonary or contagious TB infection. This determination is based on (circle one response below):

a. Negative TB screening assessment. No further testing indicated at this time.

b. Negative TST: Date Applied ___/____/_____ Initials: _____

Site: _____Product Name: _____ Lot # _____

Expiration Date: ___/_____/_____ Dose: _____

Date Read: ___/_____/_____ Induration (mm) _____ Initials: _____

c. IGRA Blood Test: Date: ____/_____/_____

Result: Positive □ Negative □ Indeterminate □

Attach report

d. Sputum Examination: AFB smear and culture. Attach report

e. Chest X-Ray: Attach report

Physician Signature: _____

Physician Printed or Typed Name: _____

Date and Time: _____