

Section A Tuberculosis Assessment

Have you had a Positive TB Exposure or Positive TB Skin Test History? (if YES, documentation required) Yes No

Symptom Review to be completed whether 'Yes' or 'No' to above

Check the symptoms listed below (must check at least one box):

- | | |
|---|--|
| <input type="checkbox"/> Persistent cough for more than 2 weeks | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Anorexia (loss of appetite) | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Bloody sputum |
| <input type="checkbox"/> Production of sputum | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> None of the above | |

Client Name: _____ Client Signature: _____ Date: ___ / ___ / ___
(Print) (Signature)

Section B Tuberculosis Screening

(Please attach all lab results / immunization records)

The following tests have been performed in my office/facility and under my supervision by medical personnel with training to place and read a PPD/skin test.

PPD/Skin Test

Placed ___ / ___ / ___ Placed by: _____
(Name) (Signature)

(Title) (License #)

Office/Facility Name: _____

Address: _____

Telephone #: _____

Read ___ / ___ / ___ Interpreted by: _____
(Name) (Signature)

(Title) (License #)

Office/Facility Name: _____

Address: _____

Telephone #: _____

Results Induration _____mm Negative Positive

OR
BCG Immunization Date ___ / ___ / ___

OR
QuantiFERON-TB-Gold Date ___ / ___ / ___

Section C Tuberculosis History

Complete Section C **only** if there is a history of positive TB exposure. **Please provide most recent Chest X-ray radiology report.**

Positive Skin Test (documentation required) Date ___ / ___ / ___

Have you been treated with TB medication? Yes No

Treatment: INH Other _____

Chest X-Ray impression relative to positive PPD: Positive Negative Date ___ / ___ / ___