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Tuberculosis Assessment

Section A Tuberculosis Assessment

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

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

☐ Chest Pain	☐ Shortness of Breath
☐ Lack of Appetite	☐ Low grade fever
☐ Weakness	☐ Blood Streaked Sputum
☐ FLU like Symptoms	☐ Clear, Yellow or Dark Sputum
☐ Night Sweats	☐ 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) (License #) (Signature)

Office/Facility Name: _____

Address:_____

Telephone #: _____

Read___/___/____ Placed by: _____ _____ _____
(Name) (License #) (Signature)

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:_____