

Section A Tuberculosis Assessment (All clients must complete section "A".)

Have you had a Positive TB Exposure or Positive TB Skin Test History (PPD, QuantiFERON-TB-Gold, T-Spot, etc)?
 Yes No (If YES, documentation required) **Symptom Review to be completed whether 'Yes' or 'No' to above**

- Have you experienced any of the following symptoms in the past year?

A) A productive cough for more than 3 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B) Hemoptysis (coughing up blood)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C) Unexplained weight loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D) Fever, Chills, or night sweats for no known reason?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
E) Persistent shortness of breath?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
F) Unexplained fatigue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
G) Chest Pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
- Have you had contact with anyone with active tuberculosis disease in the past year? Yes No
- Do you have a medical condition, or are you taking medications, which suppress your immune system? Yes No

I have read and completed the signs and symptoms for Tuberculosis screening questions above. My answers are true to the best of my knowledge. If there are any changes in my health status related to TB signs and symptoms I will report them to the Company without delay. I realize that I must have clearance from my physician to return to work if I experience above signs/symptoms of active TB.

Client Name: _____ PRINT Client Signature: _____ SIGNATURE Date: _____ MM/DD/YYYY

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: _____
MM/DD/YYYY NAME SIGNATURE

Time: _____: _____ a.m. / p.m. _____
TITLE

Manufacturer: _____ Office/Facility Name: _____

Exp Date: _____ Address: _____
MM/DD/YYYY

Lot #: _____ Telephone #: _____

Read: _____ Interpreted by: _____
MM/DD/YYYY NAME SIGNATURE

Time: _____: _____ a.m. / p.m. _____
TITLE

Office/Facility Name is the same as above.

Office/Facility Name: _____
 Address: _____
 Telephone #: _____

RESULTS and/or

BCG Immunization

QuantiFERON-TB-Gold

T-SPOT

Induration _____ mm Negative Positive

Date: _____
MM/DD/YYYY

Date: _____
MM/DD/YYYY

Date: _____
MM/DD/YYYY

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 TB Skin Test (documentation required) Date: _____
MM/DD/YYYY

Have you been treated with TB medication? Yes No

Treatment: INH Other

Chest X-Ray impression relative to positive PPD: Positive Negative Date _____
MM/DD/YYYY