

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

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)

Office/Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Read \_\_\_ / \_\_\_ / \_\_\_ Interpreted by: \_\_\_\_\_  
(Name) (Signature)

\_\_\_\_\_  
(Title)

Office/Facility Name is the same as above.

Office/Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

**Results and/or**

Induration \_\_\_\_\_ mm  Negative  Positive

BCG Immunization Date \_\_\_ / \_\_\_ / \_\_\_

QuantiFERON-TB-Gold Date \_\_\_ / \_\_\_ / \_\_\_

T-SPOT 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 TB 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 \_\_\_ / \_\_\_ / \_\_\_