Employee Tuberculosis Screening

**1. Are you from or have you lived for two months or more in Africa, Asia, Central or South America, or Eastern Europe?** 􀀘 No 􀀘 Yes If yes, list countries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Have you been diagnosed with a chronic condition that may impair your immune system?**

 􀀘 No 􀀘 Yes If yes, check all that apply:

|  |  |  |
| --- | --- | --- |
| 􀀘 Chronic steroid use  | 􀀘 Gastrectomy/intestinal bypass  | 􀀘 Diabetes mellitus  |
| 􀀘 HIV infection  | 􀀘 Crohn’s disease  | 􀀘 Dialysis/Renal failure  |
| 􀀘 Cancer of the head or neck  | 􀀘 Rheumatoid arthritis  | 􀀘 Chronic malabsorption syndromes  |
| 􀀘 Silicosis  | 􀀘 Use of TNF-α antagonist  | 􀀘 Low body weight |
| 􀀘 Leukemia | 􀀘 Lymphoma | 􀀘 Hodgkin’s Disease |
|  | 􀀘 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**3. Have you ever resided, worked or volunteered in any of the following facilities?**

 􀀘 No 􀀘 Yes If yes, check all that apply:

|  |  |  |
| --- | --- | --- |
| 􀀘 Prison  | 􀀘 Hospital  | 􀀘 Nursing home  |
| 􀀘 Homeless shelter  | 􀀘 Other long term treatment center \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**4. Do you currently have any of the following symptoms?**

􀀘 No 􀀘 Yes If yes, check all that apply:

|  |  |  |  |
| --- | --- | --- | --- |
| 􀀘 Cough > 3 weeks  | 􀀘 Unexplained fever  | 􀀘 Chest pain  | 􀀘 Chills  |
| 􀀘 Productive cough | 􀀘 Night sweats  | 􀀘 Shortness of breath | 􀀘 Loss of appetite  |
| 􀀘 Coughing up blood  | 􀀘 Unexplained wt. loss | 􀀘 Fatigue  | 􀀘 Weakness  |

**5. Have you ever had contact with a person known to have active tuberculosis?**

􀀘 No 􀀘 Yes

**6. Have you ever used injection drugs?**

􀀘 No 􀀘 Yes

**7. Have you had a tuberculin skin test before?**

􀀘 No 􀀘 Yes If yes, list where given \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_ (attach results)

**8. Have you had a chest x-ray?**

􀀘 No 􀀘 Yes If yes, list where given \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_ (attach results)

The information above is true and complete, and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and will not be released without my knowledge and written permission.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant / Employee Signature Date

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

A “yes” answer to 1-6 above may require the employee be referred to a provider for further evaluation, unless the applicant/employee can provide documentation of negative skin test in the last 12 months or negative chest x-ray. If referred, applicant/employee will be eligible to work only when cleared by physician.

**Referred to MD?** 􀀘 No 􀀘 Yes If yes, cleared to work? 􀀘 No 􀀘 Yes Date **\_\_\_\_\_\_\_\_\_\_** (attach documentation)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Administrator / Supervisor Signature Date