McLaren MACOMB

Tb Screening Questionnaire

PLEASE PRINT

Name: _____Employee ID #: _____Dept: _____

☐ New Hire ☐ 2nd Step ☐ Semi-Annual ☐ Past Positive Questionnaire ☐ Post Exposure _____

Please Read and Answer the Following Questions:

Have you ever been told you had Tb?	☐ Yes	☐ No
Have you ever lived with anyone with Tb?	☐ Yes	☐ No
Have you ever had a positive Tb test?	☐ Yes	☐ No
Have you taken Tb medications after a positive Tb test?	☐ Yes	☐ No
Have you received an MMR or any live vaccine in the past 4-6 weeks?	☐ Yes	☐ No
Were you born outside of the United States?	☐ Yes	☐ No
Have you ever received a BCG vaccination?	☐ Yes	☐ No

Please Check if you have any of these symptoms and DO NOT know what causes it

☐ Chronic cough with sputum or blood ☐ Night Sweats ☐ Shortness of Breath
☐ Weight loss with no change of eating ☐ Fever ☐ Persistent tiredness and weakness

Please check if you have the following health problems or if you take these medications

☐ Any immuno-compromising conditions ☐ Currently taking steroids ☐ Currently having chemotherapy

By signing below, I am agreeing to the following statements:

- To the best of my knowledge, I have answered all of the above correctly.
- I understand the Tb screening program and need to have my test read in 48-72 hours by the **Employee Health Nurse** or by **TST Certified Nursing Supervisor**
- I agree to inform the Employee Health Nurse if I develop any symptoms of Tb before my next Tb screening.

Signature: _____ Date:_____

Test Administration	**Test Result**
Date:_____Time:_____	Date:_____Time:_____
Site: Right or Left Forearm	Reading: Negative / Positive
Brand: _____	Induration: _____ mm
Lot #: _____	(must include induration even if "0")
Exp date:_____	
	Signature/Title:_____
Signature/Title:_____	EHS Nurse Nursing Supervisor

Follow-up Recommendation

Chest X-Ray Date: _____ Results:_____
Physician Visit : Yes/No
Deferral reason:_____
Deferred by:_____

- ___ I have been given the opportunity to ask questions regarding the CAPR.