



# RECORD OF TUBERCULOSIS SCREENING

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## SECTION A

Answer the following questions:

Do you have:

- |                                  | Yes                      | No                       |
|----------------------------------|--------------------------|--------------------------|
| 1. Unexplained productive cough? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Unexplained weight loss?      | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Unexplained appetite loss?    | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Unexplained fever?            | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Night sweats?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Shortness of breath?          | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Chest pain?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Increased fatigue?            | <input type="checkbox"/> | <input type="checkbox"/> |

**The above health statement is accurate to the best of my knowledge. I will see my physician, and/or health department if my health status changes.**

**Employee Signature:** \_\_\_\_\_

## SECTION B (CONSENT FOR PPD TB SKIN TEST)

I \_\_\_\_\_ consent to have a PPD Tuberculosis skin test. I release MAXIM HEALTHCARE SERVICES and its employees from all liability in connection with the administration and interpretation of this test.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## SECTION C (FOR ONE STEP/ANNUAL TB TESTING)

This is to certify that the above named person (a) had a Tuberculin Skin Test on \_\_\_/\_\_\_/\_\_\_ which was read as \_\_\_\_\_ mm. on \_\_\_/\_\_\_/\_\_\_.

Signature MD/RN: \_\_\_\_\_ Date: \_\_\_\_\_

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

## SECTION D (FOR TWO STEP TB TESTING)

This is to certify that the above named person (a) had a Tuberculin Skin Test on \_\_\_/\_\_\_/\_\_\_ which was read as \_\_\_\_\_ mm., on \_\_\_/\_\_\_/\_\_\_, and (b) had a second Tuberculin Skin Test on \_\_\_/\_\_\_/\_\_\_ which was read as \_\_\_\_\_ mm., on \_\_\_/\_\_\_/\_\_\_. This completes the two step Tuberculin Skin Testing process and the individual is classified as uninfected.

Signature MD/RN: \_\_\_\_\_ Date: \_\_\_\_\_

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

## SECTION E (FOR POSITIVE READING)

This is to certify that the above named person (a) had a Tuberculin Skin Test on \_\_\_/\_\_\_/\_\_\_ which was read as \_\_\_\_\_ mm., on \_\_\_/\_\_\_/\_\_\_, and (b) had a chest x-ray on \_\_\_/\_\_\_/\_\_\_ (if applicable must send copy of radiology report) which showed no sign of active inflammatory disease. This person has no symptoms suggestive of active tuberculosis, no known exposure to tuberculosis, and has completed adequate TB related surveillance. Therefore, a two-step Tuberculin Skin Test for tuberculosis is not indicated at this time.

Signature MD/RN: \_\_\_\_\_ Date: \_\_\_\_\_

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

**CXR per CDC Guidelines: Employee to complete questionnaire annually. CXR does not have to be repeated unless employee becomes symptomatic or repeat CXR is recommended by the MD.**

Revised 12/07/06