MEDSTAFF®
HEALTHCARE SOLUTIONS

Tuberculosis Assessment

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):

- ❑ Persistent cough for more than 2 weeks
- ❑ Anorexia (loss of appetite)
- ❑ Unexplained weight loss
- ❑ Production of sputum
- ❑ None of the above
- ❑ Night sweats
- ❑ Fever
- ❑ Bloody sputum
- ❑ Shortness of breath

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 ❑ Induration _____mm ❑ Negative ❑ Positive
and/or
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 ___ /___ /____

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