

**Main Line Health
Occupational Health**

Positive Tuberculosis (TB) Test Screening Form

I. Baseline Information

Last Name: _____	Employer: _____
First Name: _____	Department: _____
Social Security #: _____	Date of Birth _____
Address: _____	City _____ State ____ Zip _____
Contact Phone Number: _____	Country of Birth _____
	If not US born, year of arrival to USA : _____
Have you ever received the BCG vaccination? Y N	If yes, when: _____
Have you ever had a known exposure to tuberculosis? Y N	If yes, when: _____
Have you ever been told you had tuberculosis? Y N	If yes, when and treatment: _____

II. Reason Completing Form:

☐ **New Positive TB result: (how)** **PPD Skin test:** Date Placed: _____ Date Read: _____ Size: _____
Quantiferon TB (QFT) Blood test (not done in OH): Date of test: _____

☐ **Past history of Positive TB Test:** *complete following questions below*

1-Date of Positive Test Result: _____ Do you have the documentation with you? **Y N**
 2-Was a chest x-ray done at that time? **Y N** If yes, was it normal? **Y N** Do you have a copy of that xray report? **Y N**
 3-Did you receive anti TB medication? **Y N** How long did you take it? _____
 4-Date of last chest xray? _____ What was the result? _____ Do you have a copy of that xray report? **Y N**

III. Questionnaire

SYMPTOMS (circle "Y" for Yes, "N" for No)

Please explain any yes answers

Cough of 2 weeks or more	Y N	_____
Shortness of breath	Y N	_____
Unexplained weight loss	Y N	_____
Night sweats	Y N	_____
Unexplained fever	Y N	_____
Malaise/tiredness	Y N	_____
Anorexia/loss of appetite	Y N	_____
Known TB exposure since last visit	Y N	_____

Employee Signature: _____ Date _____

IV. For OHC Staff Use Only:

QFT ordered by HCP for confirmation: **Y N N/A** **QFT RESULT:** Negative Positive

CXR ordered by HCP*/Employer request : **Y N**

HCP comments: ☐ QFT negative- Continue annual QFT surveillance

☐ No symptoms/ negative x-ray (date _____)- continue annual questionnaire surveillance

☐ Referred to: **PMD** **State/County Health** **Other** _____

☐ Other: _____

HCP Signature: _____ Date: _____

* Policy states x-ray required at first knowledge of a positive TB test or change in symptoms