**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Please answer by marking ‘yes’ or ‘no’ to the following questions:***

**Yes \_\_\_\_\_ No \_\_\_\_\_** Birth, travel, or residence in a county with an elevated TB rate for at least 1 month (i.e. includes any country other than the United States, Canada, Australia, New Zealand, or a county in western or northern Europe).

**Yes \_\_\_\_\_ No \_\_\_\_\_** Current or planned immunosuppression, including HIV infection, organ transplant recipient, treated with a TNF-alpha antagonist (e.g. infliximab, etanercept, or others), steroids (equivalent of prednisone > 15 mg/day > 1 month) or other immunosuppressive medication.

**Yes \_\_\_\_\_ No \_\_\_\_\_** Close contact with someone who has had infectious TB disease since the last TB test.

**Mantoux Tuberculin Skin Test (TST):**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Type of Medication*** | ***Dose*** | ***Site***  ***(circle one)*** | | ***Manufacturer*** | ***Lot*** | ***Expiration***  ***Date*** | **Signature & Title of Vaccine Administrator** |
| **Purified Protein Derivative (PPD)** | 0.1 ml  (5 units)  Intradermal | Right  Left  forearm | |  |  |  | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  | | | **Ordering Provider: xxxxxxxxxxxxxxxxxx** | | | | | |

**Step 1 Results**: Date/Time Read: \_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_ Induration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_mm

Read by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Negative Positive (send to HD)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Type of Medication*** | ***Dose*** | ***Site***  ***(circle one)*** | | ***Manufacturer*** | ***Lot*** | ***Expiration***  ***Date*** | **Signature & Title of Vaccine Administrator** |
| **Purified Protein Derivative (PPD)** | 0.1 ml  (5 units)  Intradermal | Right  Left  forearm | |  |  |  | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  | | | **Ordering Provider: xxxxxxxxxxxxxxxxx** | | | | | |

**Step 2 Results**: Date/Time Read: \_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_ Induration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_mm

Read by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Negative Positive (send to HD)

*For Occupational Health use only: If individual is positive please collect the following information:*

*Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Signs and Symptoms Questionnaire for TB:**

***Please answer by marking ‘yes’ or ‘no’ to the following questions:***

**Have you experienced any of the following symptoms in the past year?**

**Yes \_\_\_\_\_ No \_\_\_\_\_** A productive cough lasting longer than three (3) weeks?

**Yes \_\_\_\_\_ No \_\_\_\_\_** Hemoptysis (coughing up blood)?

**Yes \_\_\_\_\_ No \_\_\_\_\_** Unexplained weight loss

**Yes \_\_\_\_\_ No \_\_\_\_\_** Fever, chills, or night sweats for no known reason?

**Yes \_\_\_\_\_ No \_\_\_\_\_** Chest pain

*I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge. If I develop any of these symptoms, I agree to seek immediate medical attention.*

Signature of person required to be tested Date

**Individual with history of BCG vaccine:**

**Results to IGRA received:**

Normal: \_\_\_\_\_\_

If positive send report to HD.

|  |  |  |  |
| --- | --- | --- | --- |
| ***Type of Lab Order*** | ***Date*** | **Signature & Title of Practitioner Ordering** | |
| IGRA blood test (QuantiFeron Gold or  T-Spot) |  |  | |
| **Complete lab requisition and send associate to LabCorp** | | | **Ordering Provider: xxxxxxxxxxxxxx** |

**Individual requiring a Radiographic Study of the chest:**

**Results of CXR received:**

Normal: \_\_\_\_\_\_

**Copy of CXR on file:**

**Yes \_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| ***Type of order*** | ***Date*** | **Signature & Title of Practitioner Ordering** |
| Radiographic study of the chest – Single, PA view  (chest x-ray) |  |  |
|  | | **Ordering Provider: xxxxxxxxxxxxxxxxxxxxx** |