TB Positive/ Exempt Surveillance Questionnaire

As part of our TB Surveillance Program, you are asked to complete this questionnaire and return to management.

I have experienced the following signs/symptoms:

A. Positive Cough (excessive)	YES ( ) *	NO ( )
B. Fatigue (excessive)	YES ( ) *	NO ( )
C. Weakness	YES ( ) *	NO ( )
D. Weight Loss (excessive)	YES ( ) *	NO ( )
E. Chronic Medical Condition	YES ( ) *	NO ( )
F. Night Sweats	YES ( ) *	NO ( )

* Please explain if you have answered YES to any of the above questions.

____

____

____

____

____

I am aware that should I develop any of these symptoms I should follow-up with my own physician to rule out possible TB.

Patient ______________________________ Date of birth ______________
(Printed name)

Patient ______________________________ Date ______________
(Signature)

Temperature __________ Respiration __________ MA's Initials __________

Reviewed by ______________________________ Date ______________
Physician name (print and sign)

TB SKIN TEST

Patient Name (Printed) ______________________ **Date of Birth** ______________

- TB skin tests **MUST** be read by a representative of DOC-AID Urgent Care **48-72** hours after administered. __________ (Initials)
- Skin tests read before 48 hours or after 72 hours will be invalid and must be repeated prior to the release of any test result paperwork. There will be an additional charge for any repeat testing. __________ (Initials)
  - ~ **I have not had a TB skin test performed in the past 12 months.** __________ **(Initials)**
  - ~ **I have not had a POSITIVE TB skin test in the past.** __________ **(Initials)**
- If a test comes back POSITIVE, I agree to be evaluated by a Doc-Aid physician, resulting in an office visit at an additional fee __________. (Initials)

I have read and understand the statement above. ______________________

Patient/ Guardian's Signature

Step 1

TB Skin Test ________ Date ________ Time am am / pm ________ Site ________ Mfr. ________ Lot # ________ Exp.

Administered By ______________________ Name & Title ☐ Preplacement ☐ Periodic Screen ☐ Exposure (requires Step 2)

To Be Read ________ Date ________ Day after ________ am pm ________ Date ________ Day By ________ am pm

Reading ________ Date ________ Time am pm ________ ☐ 0 mm induration ________ mm of induration ☐ Over 72 hours, must be repeated

Read By ______________________

Name (sign and print) & Title

Step 2 - For anyone not able to document a TB test done in the last 12 months.

TB Skin Test ________ Date ________ Time am pm ________ Site ________ Mfr. ________ Lot # ________ Exp.

Administered By ______________________ Name & Title ☐ Preplacement (1 - 3 weeks after Step 1) ☐ Exposure (5 - 6 weeks after Step 1)

To Be Read ________ Date ________ Day after ________ am pm ________ Date ________ Day By ________ am pm

Reading ________ Date ________ Time am pm ☐ 0 mm induration ________ mm of induration ☐ Over 72 hours, must be repeated

Read By ______________________

Name (sign and print) Title

Symptom Assessment Questionnaire is to be filled out if test result comes back POSITIVE.--PAGE 2 REVERSE

Referral (if indicated)

Pulmonary Medicine ______________ / ______________ / ______________

Physician **Appointment Date** **Time**

Intradermal skin testing, Mantoux technique, 0.1 mL solution.

The diameter of induration (palpable raised hardened area) around site of injection is measured across the forearm. Do not measure erythema (redness).