

HOWARD COUNTY GENERAL HOSPITAL, INC.

Occupational Health

Tuberculosis Screening Form

Phone: 410-740-7838

Fax: 410-740-7685

PRINT: First Name _____ Last Name _____ SSN/last 4 digits: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: F M Contact phone # _____ Email: _____

Dept: _____ Job Title: _____ Manager Name: _____ / Phone # _____

*Do you have contact with patients or work in patient care areas? Yes No

Please answer the following questions:

1.	Your last TB screening was a:	<input type="radio"/> TB Skin Test	<input type="radio"/> TB Blood Test	<input type="checkbox"/> Questionnaire
	*When: _____	Result: <input type="radio"/> UNSURE	<input type="radio"/> NEG	<input type="radio"/> POS / Size: _____mm induration
				<input type="checkbox"/> Asymptomatic
2.	Was a chest x-ray done after that TB test?	<input type="radio"/> YES	<input type="radio"/> NO	<input type="radio"/> UNSURE
3.	Have you EVER had a positive TB test result?	<input type="radio"/> YES	<input type="radio"/> NO	<input type="radio"/> UNSURE
4.	Did you ever take medication for TB?	<input type="radio"/> YES	<input type="radio"/> NO	<input type="radio"/> UNSURE
	*If "yes", Name of medication taken: _____			
	*Number of months medication taken for: _____			
5.	Country of Birth: _____			
6.	Have you had the BCG vaccine (a vaccine for TB)?	<input type="radio"/> YES	<input type="radio"/> NO	<input type="radio"/> UNSURE
7.	Do you have any of the following symptoms?	<input type="radio"/> NONE		
	<input type="radio"/> Cough	<input type="radio"/> Fatigue	<input type="radio"/> Fever	<input type="radio"/> Night Sweats
	<input type="radio"/> Bloody, yellow or green sputum	<input type="radio"/> Decreased Appetite	<input type="radio"/> Chest Pain	<input type="radio"/> Weight Loss
8.	Check all that apply to you:			
	<input type="radio"/> Recent live vaccines: measles, MMR, varicella, flu mist intranasal vaccine, typhoid, etc. (Delay TST for 4 weeks)			
	<input type="radio"/> Do you scrub up to your elbows for any procedures (place TST in upper arm)			

Employee Signature: _____ Date: _____

F O R O F F I C E U S E O N L Y	*	Employer: <input type="checkbox"/> HCGH <input type="checkbox"/> JHH <input type="checkbox"/> JHHS <input type="checkbox"/> Volunteer <input type="checkbox"/> BSI <input type="checkbox"/> Sodexo <input type="checkbox"/> Student/Extern <input type="checkbox"/> Contractor <input type="checkbox"/> Other: _____												
	*	Reason for Test: Pre-employment: <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> Annual Exposure: <input type="checkbox"/> Baseline <input type="checkbox"/> Post												
	1	Tuberculin Skin Test (5TU Solution) Note: Evaluate risk category: <input type="radio"/> 5mm <input type="radio"/> 10m <input type="radio"/> 15mm <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">Date/Placed Time</td> <td style="width:15%;">Site ()mm</td> <td style="width:25%;">Administered by (PRINT)</td> <td style="width:15%;">Manufacturer</td> <td style="width:10%;">Lot#</td> <td style="width:10%;">Exp. Date</td> </tr> <tr> <td>Date/Read Time</td> <td>mm induration (None = 0, if reactive must see OHS)</td> <td>POS NEG</td> <td>Appearance</td> <td colspan="2">Signature</td> </tr> </table>	Date/Placed Time	Site ()mm	Administered by (PRINT)	Manufacturer	Lot#	Exp. Date	Date/Read Time	mm induration (None = 0, if reactive must see OHS)	POS NEG	Appearance	Signature	
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2	IGRA: <input type="radio"/> T-spot <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%;">Date Collected</td> <td style="width:20%;">Collected by (PRINT NAME)</td> <td style="width:15%;">Result</td> <td style="width:20%;">Date Employee Notified</td> <td style="width:25%;">Staff Initial</td> </tr> </table>	Date Collected	Collected by (PRINT NAME)	Result	Date Employee Notified	Staff Initial								
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3	Known Positive Symptom Review: <input type="radio"/> Sympton Review <input type="radio"/> Documentation in ICMS <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:40%;">Date CXR</td> <td style="width:15%;">Result</td> <td style="width:45%;">Staff Initial</td> </tr> </table>	Date CXR	Result	Staff Initial										
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Follow-up for Positive Result: Date CXR Req given: _____ Date CXR Completed: _____ Result: _____
Copy to Employee _____ Date LTBI Questionnaire Given: _____ Date Completed: _____ RN Initials: _____
Site Code: LUA - Left Upper Arm LFA - Left Forearm RUA - Right Upper Arm RFA - Right Forearm

TB SCREENING COMPLETED (DATE): _____ **OHS SIGNATURE:** _____