HOWARD COUNTY GENERAL HOSPITAL, INC.
Occupational Health

Phone: 410-740-7838 **Tuberculosis Screening Form** **Fax: 410-740-7685**

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

Home Address:_____ City:_____State:_____ Zip:_____

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

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

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

Please answer the following questions:

1. **Your last TB screening was a:** o TB Skin Test o TB Blood Test ☐ Questionnaire

   *When:_____ Result: o UNSURE o NEG o POS / Size: _____mm induration ☐ Asymptomatic

2. Was a chest x-ray done after that TB test? o YES o NO o UNSURE
3. Have you EVER had a positive TB test result? o YES o NO o UNSURE
4. Did you ever take medication for TB? o YES o NO o 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)? o **YES** o **NO** o **UNSURE**
7. **Do you have any of the following symptoms?** o **NONE**
   o Cough o Fatigue o Fever o Night Sweats o Decreased Appetite o Chest Pain o Weight Loss
   o Bloody, yellow or green sputum
8. **Check all that apply to you**:
   o Recent live vaccines: measles, MMR, varicella, flu mist intranasal vaccine, typhoid, etc. (Delay TST for 4 weeks)
   o Do you scrub up to your elbows for any procedures (place TST in upper arm)

Employee Signature:_____ Date:_____

FOR OFFICE USE ONLY

* Employer: ____HCGH ____JHH ____JHHS ____Volunteer ____BSI ____Sodexho ____Student/Extern
____Contractor ____Other:_____

* Reason for Test: Pre-employment: ____1st ____2nd ____Annual Exposure: ____Baseline ____Post

1 **Tuberculin Skin Test (5TU Solution)** **Note: Evaluate risk category:** o **5mm** o **10m** o **15mm**

Date/Placed Time | Site | Administered by (PRINT) | Manufacturer | Lot# | Exp. Date

( )mm

Date/Read Time | mm induration (None = 0, if reactive must see OHS) | POS | NEG | Appearance | Signature

2 **IGRA:** o **T-spot**

Date Collected | Collected by (PRINT NAME) | Result | Date Employee Notified | Staff Initial

3 **Known Postive Symptom Review:**

o Sympton Review o Documentation in ICMS | Date CXR | Result | Staff Initial

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:**_____

1803-1 (03/11/11) Reading between 48 and 72 hours _____