JOHNS HOPKINS
UNIVERSITY & MEDICINE

Employee/Occupational Health Tuberculosis (TB) Screening

First Name _____ Last Name_____ Date of Birth: _____

Home Address: _____City: _____State:_____ Zip:_____

Last 4 SS#: _____ Cell phone #_____Work # _____ Email:_____

1. Have you EVER had a positive TB test result (via skin testing or through T-spot or Quantiferon blood testing)? ☐ YES ☐ NO ☐ UNSURE

2. Date of last TB Testing:_____ Result:_____ If this result was *positive* was this a conversion? ☐ YES ☐ NO ☐ UNSURE

3. Have you ever needed a chest x-ray due to TB Testing? ☐ YES ☐ NO *If *YES*-date of last chest x-ray:_____ Results:_____

4. Have you ever lived outside the U. S. for more than 1 month? ☐ YES ☐ NO *If *YES*-which countries:_____

5. Country of Birth: _____ Have you had the BCG vaccine (a vaccine for TB): ☐ YES ☐ NO ☐ UNSURE

6. Do you have a weakened immune system or are you currently taking any immunosuppressive medication? This can be caused by steroids, chemotherapy, medications for rheumatologic disease, OR because of having cancer, an organ transplant, major stomach surgery or uncontrolled diabetes. ☐ YES ☐ NO ☐ UNSURE

7. Have you had close contact with someone who has had infectious TB disease since your last TB test? ☐ YES ☐ NO ☐ UNSURE

8. Have you ever had Tuberculosis? ☐ YES ☐ NO ☐ UNSURE Did you ever take medication for TB? ☐ YES ☐ NO ☐ UNSURE
*If "*YES*", Medication Name/How Long Taken: _____

11. Have you ever been told to never get any more TB Skin tests? ☐ YES ☐ NO

12. Do you have any of the following symptoms during the past year for more than 2 weeks not associated with a specific illness? ☐ **NONE**

☐ Chest pain	☐ Fatigue/weakness	☐ Persistent fever (over many days > 100.4 F)
☐ Soaking night sweats	☐ Chronic cough lasting more than 3 weeks	☐ Loss of appetite
☐ Coughing up phlegm or blood	☐ Difficulty breathing/wheezing	☐ Unexplained weight loss of more than 5 pounds

*****Signature: _____ Date:_____**

Clinician Name/Signature:_____ Date:_____

FOR OFFICE USE ONLY

*	**Reason for Test: Pre-employment:** ☐ **1st** ☐ **2nd** ☐ **Annual** ☐ **AESP** ☐ **Exposure:** ☐ Baseline ☐ Post
1	**Tuberculin Skin Test** Date placed Site Administered by (PRINT) Manufacturer Lot # Exp. Date Date read NEG mm induration (No Induration = 0 mm) POS Appearance Reader
2	**IGRA** Date Collected: _____ Time Collected: _____ AM PM Collected by:_____ # of Tubes:_____ RESULT:_____ Reviewed by Staff (Initials): _____
3	**Known Positive Symptom Review:** ☐ Symptom Review Completed ☐ CXR date:_____ Result: _____ Staff initials: _____
4	**Follow-up for Positive Result:** Date CXR completed:_____ Result: _____ Health Department notified per state guidelines (date/staff initials): _____
5	Surveillance Program based off of TB screening: ☐ Yes ☐ No If yes: ☐ Annual TB Screening (KPR, High Risk Staff) OR ☐ Annual TB screening & TB testing per current protocols *Annual TST or IGRA is not indicated except for designated high-risk groups based on the facility risk assessment and recommendations.

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