Main Line Health
Occupational Health

Positive Tuberculosis (TB) Test Screening Form

I. Baseline Information

Last Name:_____ Employer:_____

First Name:_____ Department:_____

Social Security #: _____ Date of Birth_____

Address: _____ City _____ State ____ Zip _____

Contact Phone Number:_____ Country of Birth_____

If not US born, year of arrival to USA :_____

Have you ever received the BCG vaccination? **Y N** If yes, when:_____

Have you ever had a **known** exposure to tuberculosis? **Y N** If yes, when:_____

Have you ever been told you had tuberculosis? **Y N** If yes, when and treatment:_____

II. Reason Completing Form:

☐ **New Positive TB result:** (*how*) **PPD Skin test:** Date Placed: _____ Date Read:_____ Size:_____

Quantiferon TB (QFT) Blood test (*not done in OH*): Date of test**:** _____

☐ **Past history of Positive TB Test:** *complete following questions below*

1-Date of Positive Test Result: _____ Do you have the documentation with you? **Y N**

2-Was a chest x-ray done at that time? **Y N** If yes, was it normal? **Y N** Do you have a copy of that xray report? **Y N**

3-Did you receive anti TB medication? **Y N** How long did you take it?_____

4-Date of last chest xray?_____ What was the result?_____ Do you have a copy of that xray report? **Y N**

III. Questionnaire

SYMPTOMS (circle "Y" for Yes, "N" for No)		Please explain any yes answers
Cough of 2 weeks or more	**Y N**	_____
Shortness of breath	**Y N**	_____
Unexplained weight loss	**Y N**	_____
Night sweats	**Y N**	_____
Unexplained fever	**Y N**	_____
Malaise/tiredness	**Y N**	_____
Anorexia/loss of appetite	**Y N**	_____
Known TB exposure since last visit	**Y N**	_____

Employee Signature:_____ Date _____

IV. For OHC Staff Use Only:

QFT ordered by HCP for confirmation: Y N N/A **QFT RESULT:** Negative Positive

CXR ordered by HCP*/Employer request : Y N

HCP comments: ☐ QFT negative- Continue annual QFT surveillance

☐ No symptoms/ negative x-ray (date_____)- continue annual questionnaire surveillance

☐ Referred to: PMD State/County Health Other _____

☐ Other: _____

HCP Signature: _____. Date: _____

** Policy states x-ray required at first knowledge of a positive TB test or change in symptoms* *11.13.13*

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