## 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	_	Country of Birth
Contact Phone Number:		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:		
☐ Newly Positive TB result: (how) PPD Skin test	: Date P	Placed: Date Read: Size:
Quantiferon TB (	QFT) Blo	ood test (not done in OH): Date of test:
☐ Past history of Positive TB Test: complete following	ng questic	ons below
-Date of Positive Test Result: Do you ha	ıve docum	nentation? Y N
-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
-Did you receive anti TB medication? Y N How long of	did you tal	ke it?
-Date of last chest xray? What was the r	esult?	Do you have a copy of that xray report? Y N
III. Questionnaire		
SYMPTOMS (circle "Y" for Yes, "N" for No)	Plea	ase 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 YN		
Employee Signature:		Date
IV. For OHC Staff Use Only:		
QFT ordered by HCP for confirmation: Y N N/A	Α	QFT RESULT: Negative Positive
CXR ordered by HCP*/Employer request: Y N		
HCP comments: ☐ QFT negative- Continue annual QFT	surveillar	nce
☐ No symptoms/ negative x-ray (date_		)- continue annual questionnaire surveillance
☐ Referred to: PMD State/Cou	ınty Healt	h Other
☐ Other:		
		Date:
* Policy states x-ray required at first knowledge of a positive TB test or cha	anae in svmr	otoms 03.06.12