Tuberculosis Symptom Screening Questionnaire

This form is to be used for persons who are required to have TB screening for employment, post-secondary educational institution admission, long term residential care admission, correctional facility intake, or fulfillment of other statute or regulation. *Part A should be completed by the person for whom the TB Skin Test is required. A healthcare professional must evaluate the answers and assign a recommendation from Part B.*

- **Prior to using the form, all responsible facilities (skilled nursing facilities, home health care etc.) should verify that the suggested process is acceptable to their regulatory authority.**

PART A

1. Have you experienced any of the following symptoms in the past year?

a.) A productive cough for more than 3 weeks?	Yes	No
b.) Hemoptysis (coughing up blood)?	Yes	No
c.) Unexplained weight loss?	Yes	No
d.) Fever, Chills, or night sweats for no known reason?	Yes	No
e.) Persistent shortness of breath?	Yes	No
f.) Unexplained fatigue?	Yes	No
g.) Chest Pain?	Yes	No
2. Have you had contact with anyone with active tuberculosis disease in the past year?	Yes	No
3) Do you have a medical condition, or are you taking medications, which suppress your immune system?	Yes	No

3. Why are you required to have a TB Skin Test?

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Please provide details to any question answered "Yes".

I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.

______________________ ______________________ ________

Signature of person required to be tested   Printed Name   Date

PART B

Upon review of the responses to the questionnaire and discussion with the person for whom the tuberculosis evaluation is required, I recommend as follows:

_______There is no indication this person has active tuberculosis at this time. ***Interferon Gamma Release Assay (IGRA) TB Blood Test may be considered as an alternative, if practicable. (client is insured, or can afford out of pocket).***

_______Further evaluation, including a TB Skin Test, Interferon Gamma Release Assay or other medical evaluation is indicated, and should be completed prior to work placement or admission to a facility.

______________________ ______________________ ________

Healthcare Professional Signature   Printed Name   Date

______________________ ______________________

Agency/Practice Name   Contact Phone