TB SCREENING QUESTIONNAIRE

________________ Last name	________________ First name	________________ Middle name	____/_____/_____ Date of birth
________________ Address	________________ City	________________ State	________________ Zip
________________ Home phone	________________ Cell or work phone	_____/_____/_____ Today's date	

CIRCLE ANY OF THE BELOW SYMPTOMS YOU HAVE TODAY

Cough **Coughing up blood** **Fever** **Weight loss** **Tiredness** **Night sweats**

PLEASE ANSWER THESE QUESTIONS

Why do you need a TB test today?			
Have you ever had a positive TB skin test or TB blood test?	Yes	No	Don't Know
Have you had a severe reaction to a TB skin test?	Yes	No	Don't Know
Have you ever taken medication for tuberculosis?	Yes	No	Don't Know
What country were you born in?			
If you were not born in the U.S., when did you come here?			
Have you had the BCG vaccine?	Yes	No	Don't Know
Have you been in contact with someone who has TB disease?	Yes	No	Don't Know
Have you ever used injection drugs?	Yes	No	Don't Know
Do you have HIV/AIDS?	Yes	No	Don't Know
Do you have any diseases that could affect your immune system such as cancer, leukemia or other?	Yes	No	Don't Know
Do you have diabetes?	Yes	No	Don't Know
Do you have severe kidney disease?	Yes	No	Don't Know
Are you underweight or do you have a disease which affects how you absorb food and nutrients?	Yes	No	Don't Know
Have you had an intestinal bypass or gastrectomy?	Yes	No	Don't Know
Do you take any prescription medications? List them below:	Yes	No	Don't Know

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Name: ______________________________ ______________________________

Last First

CONSENT TO TESTING

I have received information about the TB skin test. I had a chance to ask questions which were answered to my satisfaction. I agree to return in 48-72 hours to have the test read. I understand the risks and benefits of the TB skin test and request that the test be given to me. I understand that if I am symptomatic for TB or if the TB skin test is positive, results may be communicated to the physician with whom I will follow-up if medical care is needed.

______________________________ ______________________________

Signature **Date**

DO NOT COMPLETE, FOR NURSE

	TST #1	TST #2
Administration		
Name of person giving test		
Date and time administered		
Location (circle)	L forearm R forearm	L forearm R forearm
Tuberculin manufacturer		
Tuberculin exp. date and lot #		
Administrator signature		
Results (48-72 hours)		
Date and time read:		
Number of mm of induration: (across forearm)	______ mm	______ mm
Interpretation of reading (circle)	Positive** Negative	Positive** Negative
Reader's signature		

****Interpreting the TST**

≥ **5 mm** is positive for:

- HIV infected
- Recent contacts
- People with fibrotic changes on CXR
- Patients with organ transplant and others on immunosuppressant drugs (including prolonged course of oral or intravenous corticosteroids or TNF alpha inhibitors)

≥ **10 mm** is positive for:

- Recent immigrants (≤5 yrs) from high TB burden countries
- Injection drug users
- Mycobacterial lab workers
- People who live/work in high risk congregate settings (health care workers, long term care, correctional facilities)
- Children younger than 4 years
- Infants, children and adolescents exposed to adults in high risk categories
- People with:
  Diabetes, severe kidney disease, silicosis, cancer of head or neck, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, intestinal bypass or gastrectomy, chronic malabsorption syndromes, low body weight

≥ **15 mm is positive** if there are no known TB risk factors