Attachment #2 Tuberculosis (TB) Screening/Respiratory Assessment: ALL must complete Parts A, B, C

NAME:____ DOB _____________ Dept: Volunteer_______________

A. RISK assessment:

1. **Do you have any history of a Positive Tuberculosis Test** (Skin (PPD/TST) or Blood)?_________
   If Yes: When was your FIRST Positive TB test? ___________. Do you have proof? _______
   Did you take a complete course of medication for TB (usually 4 - 12 months)? ______
   If yes, what did you take?______________________, for how many months**?______**

2. Have you lived in another Country?______ Where?:_______________How many years?_______

3. Are you currently Immune Suppressed? _______ If yes, how?_________________

4. Have you had prolonged close contact with someone with Tuberculosis? __________

B. SYMPTOM evaluation: Do you have any of these symptoms of contagious TB? Circle Yes or No

1. Fever / Chills………………………………………………………………… Yes / No
2. Loss of appetite………………………………………………………………Yes / No
3. Coughing up blood……………………………………………………………Yes / No
4. Unexplained Weight Loss……………………………………………………Yes / No
5. Tires easily (without a reason)………………………………………………..Yes / No
6. Night Sweats (other than menopause)………………………………………Yes / No
7. Coughing frequently for greater than 3 weeks………………………………Yes / No

Volunteer SIGNATURE: ____ DATE:__________

C. TB Testing (must be with in past 3 months):

TB Blood test: (QFTG/QFTplus4T/TSPOT) **Date Collected- ___________ Result: _____________**
OR
TB Skin test: (2 Step PPD/TST tuberculosis test):

PPD#1: Date plant- _____________ Date read- ____________ Reading (mm) _____

PPD#2: Date plant- _____________ Date read- ____________ Reading (mm) _____

D. Respiratory Assessment: Required for Positive Symptoms or Positive TB test (or history of positive test).

1. **CXR (**PA, w/in 1 year**)** Date:__________ Result:______________

2. TB blood test (if not already done): Date:__________ Result: ____________

3. Exam: Coughing:______ Temp:______ BMI: _______ Lung Exam (Spec Atten Upper Lobes):__________

I attest the above-named Individual has completed ALL medical requirements listed above in Attachments I and II, is free of communicable disease, and if any of their viral antibodies are negative/equivocal, they are currently compliant with the associated vaccine series schedule. All documentation is retained in my Medical Facility and will be provided if requested.

Medical Provider: ____ ___________________________ __________
(MD, DO, APN, PA) PRINT Name, Title Sign Date

Phone#:______________________ License#___________________ Address:_______________________________________

RWJBH Employee Health Only:
Reviewed by:________________________________ TB Risk category:_________ ENTER into AGILITY: ____________