OLMSTED MEDICAL CENTER

Tuberculosis (TB) Screening

Patient Name: _____ **Company:** _____

Date of Birth: _____ **Company Contact:** _____

Patient Address: _____ **Company Phone:** _____

_____ **Company Fax:** _____

Patient Phone: _____ **Bill to:** ☐ Company ☐ Self

County of Residence: _____ ☐ Initial Screening ☐ Annual Review

New Hire Position/Start Date: _____ ☐ First Step ☐ Second Step

History:

1. Have you ever spent more than 30 days in a country with an elevated TB rate? This includes all countries except those in Western Europe, Northern Europe, Canada, Australia, and New Zealand.
   - ☐ Yes, I have been in a foreign country for greater than or equal to 30 days **(no including those listed above)**
   - ☐ No, I have not been in any country for greater than or equal to 30 days **(except those listed above)**
2. Have you had close contact with anyone who had active tuberculosis since your last TB test?
   - ☐ Yes: date _____
   - ☐ No
3. Have you ever been diagnosed with active tuberculosis disease?
   - ☐ Yes: date _____
   - ☐ No
4. Have you been diagnosed with latent tuberculosis infection *or* had a positive skin test *or* a positive blood test for tuberculosis?
   - ☐ Yes, one or more of these is true for me
   - ☐ No, none of these is true for me
5. Have you been treated with medication for tuberculosis *or* for a positive TB test (example: taken "INH")?
   - ☐ Yes: If yes, what year, with which medication, for how long, and did you complete the treatment course?

     _____
   - ☐ No
6. Do you have a weakened immune system for any reason including organ transplant; recent chemotherapy; poorly controlled diabetes; HIV infection; cancer; or treatment with steroids for more than one month, immune-suppressing medications such as TNF-alpha antagonist, or another immune-modulator? (If you are not sure, ask your Occupational Health provider.)
   - ☐ Yes, one or more of these is true for me
   - ☐ No, none of these is true for me
7. Have you received any vaccination within the last four weeks?
   - ☐ Yes: date _____
   - ☐ No
8. Have you ever received the BCG (immunization for tuberculosis)?
   - ☐ Yes: date _____
   - ☐ No
9. Have you ever received a Tuberculin Skin Test (TST)?
   - ☐ Yes: date _____
   - ☐ No

Do you currently have any of the following symptoms?

1. A cough that has lasted longer than three weeks with sputum production	☐ Yes	☐ No
2. Unexplained fever for more than three weeks	☐ Yes	☐ No
3. Bloody sputum	☐ Yes	☐ No
4. Unintended weight loss greater than 10 pounds	☐ Yes	☐ No
5. Drenching night sweats	☐ Yes	☐ No
7. Unexplained fatigue for more than three weeks	☐ Yes	☐ No

Patient Signature: _____ **Date:** _____

For OMC use:

☐ **Tuberculin Skin Test (TST) (See documentation below.)**
☐ **QuantiFERON® blood draw (See QuantiFERON® Results and Explanation)**
☐ **Tuberculin Evaluation by Clinician Needed**

Questions Reviewed by: _____ **Date:** _____

TST Administered by: _____
(Legibly Print Full Name and Title or Symbol)

Date: _____ **Time:** _____ **AM PM** ❑ Right Forearm ❑ Left Forearm

Tuberculin Vial Information: Lot #: _____ **Expiration Date:** _____ **Manufacturer:**_____

Resulted by: _____ **Clinic Name:** _____
(Legibly Print Full Name and Title or Symbol) (If read at any location other than OMC)

Date: _____ **Time:** _____ **AM PM** ❑ Right Forearm ❑ Left Forearm

Result: _____ mm ❑ Positive ❑ Negative **Comments:** _____

Patient Signature: _____ **Date:** _____

If unable to return to OMC's Rochester Southeast Clinic for TST reading, please fax to 507.292.7069.

Olmsted Medical Center, 210 Ninth Street SE, Rochester MN 55904; phone 507.292.7144

Translated Versions – Consent – Tuberculosis (TB) Screening
English – 2042624 Spanish – 2112625 Somali – 2112725