Tuberculosis Screening Form

Morehouse School of Medicine
Student Health / Employee Health Wellness Center
Phone: (404) 616-4600
Email: SHWCrequests@msm.edu

MSM / MHC _____
_____
Volunteer _____
Other _____

Name: _____ **Date of Birth:** _____
Classification: _____ **ID#** _____
Contact Phone # _____ **Address**_____

This Tuberculosis Screening form must be completed annually. Based on your responses, a PPD skin test, QuantiFERON and/or a CXR may be required for further evaluation.
Even if not required by our screening protocol, you may request PPD skin testing. If you have a PPD skin test placed, you must return in 48-72 hours for the reading.

Do you have a history of testing positive for TB infection? Yes☐ No☐ If Yes, when? _____

Have you ever received BCG vaccine? Yes☐ No☐ If Yes, when?_____

Since your last Annual Health Screen: (Please explain yes answers below)

Have you been exposed to someone known or suspected of having TB? Yes☐ No☐

Have you been tested for TB? Yes☐ No☐ If yes when, where, and what were the results?

Have you traveled outside of the U.S.? Yes☐ No☐ If yes where, for how long, and for what purpose

Were you prescribed steroids, "biologics" (for autoimmune diseases), chemotherapy? Yes☐ No☐

Please explain: _____
_____

Tuberculosis Symptoms	**Onset and Duration of Symptoms**
1. Cough for ≥ 2 week duration □ **yes** □ **no**	
2. Coughing up Blood □ **yes** □ **no**	
3. Fever □ **yes** □ **no**	
4. Night Sweats □ **yes** □ **no**	
5. Unexplained Weight Loss □ **yes** □ **no**	**Amount:**
6. Unusual weakness or fatigue □ **yes** □ **no**	

Employee Signature_____**Date**_____

MOREHOUSE SCHOOL OF MEDICINE

NAME: _____

Classification _____

For Student / Employee Health use:

Check applicable section and provide comments:

☐ **Known prior LTBI (complete numbers 1 to 4)**

1. Prior completion of LTBI treatment

☐ **Documented**

☐ **Unknown or not documented or not treated**

☐ **LTBI treatment offered today and accepted**

☐ **LTBI treatment offered today and declined**

2. CXR history:

Most recent CXR: _____ **mm/dd/yyyy**

Result:

☐ **Completely normal**

☐ **Calcified hilar node(s)**

☐ **Apical scarring**

☐ **Other abnormality:** _____

3. Exposure risks in the past year:

☐ **None**

☐ **Possible healthcare exposure**

☐ **Possible community exposure in U.S.**

☐ **Possible exposure abroad in a TB endemic country** _____ **(specify)**

4. Symptoms:

☐ **Yes**

☐ **No**

☐ **Prior testing for LTBI was negative (complete numbers 1 to 3)**

1. Two step testing was done at baseline or there have been multiple prior negatives

☐ **Yes**

☐ **No (i.e. only a single TST was done at baseline and no subsequent TSTs were placed)**

2. Exposure risks in the past year:

☐ **None**

☐ **Possible healthcare exposure**

☐ **Possible community exposure in U.S.**

☐ **Possible exposure abroad in a TB endemic country** _____ **(specify)**

3. Symptoms:

☐ **Yes**

☐ **No**

Assessment for the current annual health screen (check one box):

☐ **No specific testing indicated at this time, return for annual TB screen next year**

☐ **TB skin testing indicated by identified exposure risk but no symptoms**

☐ **TB skin testing requested by Student / Resident**

☐ **CXR indicated (symptoms +/- exposure risk)**

Comments:

Nurse Signature_____ **Date:** _____