

## 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 <u>not</u> 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 |

**continue on next page** —————>

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                   |
|---|--------------------------|--------------------------|
| <b>Administration</b>                                   |                          |                          |
| 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:<br>( <u>across</u> 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