TUBERCULIN SCREENING

Last name ______ First name ______ Middle initial ______ Home phone number ______

Job title ______ Facility/Worksite ______ Work number ______

TUBERCULOSIS (TB) HISTORY

Have you ever had active tuberculosis? .... ☐ No ☐ Yes Year ______
Have you ever been treated for latent TB infection?.................... ☐ No ☐ Yes Year ______
Have you ever had a positive TB skin test?................................ ☐ No ☐ Yes Year ______
Have you ever had a chest X-ray for TB?................................... ☐ No ☐ Yes Year ______
Have you ever had BCG vaccine?... ☐ No ☐ Yes Year ______
Were you born outside of the United States? .... ☐ No ☐ Yes Country ______
Have you had a live vaccine in the last 30 days, such as MMR or Varicella?...................... ☐ No ☐ Yes
If yes or uncertain to any of the above, please explain and give dates (approximate):

______

SYMPTOM CHECK (Check appropriate box and explain if yes)

Have you had a new unexplained cough for the last 3 weeks?... ☐ No ☐ Yes Explain ______
Do you ever cough up blood? .... ☐ No ☐ Yes Explain ______
Have you experienced an unexplained weight loss of at least 10 pounds in the last 3-6 months?.. ☐ No ☐ Yes Explain ______
Do you have unexplained night sweats? .... ☐ No ☐ Yes Explain ______
Have you had unexplained fevers in the last 6 months? .... ☐ No ☐ Yes Explain ______
Have you been experiencing unusual fatigue?........................... ☐ No ☐ Yes Explain ______

SELECT PROGRAM/CONSENT

☐ **Mandatory Screening Program**
In compliance with DOC 890.610 Tuberculosis Program for Employees Contract Staff, and Volunteers, my position has been identified as high risk for occupational exposure to tuberculosis. I am therefore directed to receive a Tuberculin screening test, at no cost to me, before I am eligible to begin or continue working in this position.

☐ **Voluntary Screening Program**
I am hereby given the opportunity to be tested for tuberculosis at no charge to me.

☐ **Voluntary Screening Program only:** I choose not to consent to the injection of tuberculin PPD skin test

☐ I hereby consent to the injection of tuberculin PPD skin test. I Further understand that my skin test must be read and documented by a nurse or physician no sooner than 72 hours after injection time. A positive reading will require follow-up by a health care provider.

☐ I choose not to consent to the injection of tuberculin PPD skin test participate in the skin testing but will bring acceptable documentation to the Occupational Nurse Consultant within the next 7 days.

______ ______
Employee/Contract staff/Volunteer signature Date

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Reason for testing: ☐ Mandatory ☐ Routine/repeat ☐ Voluntary
Reason for not testing: ☐ Not mandatory position ☐ Document prior positive/history of TB
☐ Other (Explain): ______

Date administered (1 step)	By (print)	Brand	Lot #	
Date read	By (print)		PPD results	mm
Date administered (f/u)	By (print)	Brand	Lot #	
Date read	By (print)		PPD results	mm
Referred for follow-up appointment/x-ray? ☐ Yes ☐ No	If yes, where?		Date of referral	
Nurse signature		Date signed		

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.

Distribution: **ORIGINAL** - Employee Occupational Health Record (EOHR) **COPY** - Employee/Contract staff/Volunteer