

Beth-El College of Nursing & Health Sciences
University of Colorado at Colorado Springs

TB Screening Form

Screening: New Annual F/U for Exposure dated: _____ Source: _____

Student Name: _____ Student ID Number: _____

Home Phone: _____ Date: _____

Yes No 1. Have you ever had a positive tuberculin skin test?

(If Yes, complete the questions in the box below. If No, skip the box.)

Yes No 2. Medication Allergies:

Yes No 3. Have you ever had a BCG (Bacillus Calmette-Guerin) Tuberculosis vaccine?

Yes No 4. Are you taking any long-term systemic steroid (cortisone or prednisone) or immunosuppressant medication?
This *does not* include asthma inhalers.

Yes No 5. Do you have any symptoms such as a productive, prolonged cough (over 3 weeks duration), fever, chills, night sweats, easy fatigability, loss of appetite, unplanned weight loss or bloody sputum?

Yes No 6. In the last six weeks, have you received a live vaccine (MMR, Chicken Pos, Typhoid)?

Yes No 7. Are you pregnant or breast-feeding?

What year was your TB test first positive? _____ Don't know <input type="checkbox"/>		
Was it a <input type="checkbox"/> PPD? <input type="checkbox"/> Tine Test? <input type="checkbox"/> Don't know		
What was the date of your last Chest X-ray? _____ Don't know <input type="checkbox"/>		
How many follow-up Chest X-rays have you had? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> More <input type="checkbox"/> Don't know		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Were you recommended for a course of medication or INH therapy?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, did you complete the medication or INH therapy?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any symptoms such as productive, prolonged cough (over 3 weeks duration), fever, chills, night sweats, easy fatigability, loss of appetite, unplanned weight loss or bloody sputum?

I have read or have had explained to me information about tuberculosis and screening. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of this screening. I request that the screening be given to me (or the person named for whom I am authorized to make this request). I understand all side effects or reactions are to be reported to my physician or the health care professional administering this screening.

Signature: _____ Date: _____

Nurse's Signature: _____ Date: _____

Follow-up: Past positive, asymptomatic, f/u complete Nurse's signature _____

Referred for Chest X-Ray on _____ (date) Results _____

Referred to: _____ on _____ (date)

I have discussed the above screening information with _____ and find her/him to be substantially free of tubercular health concerns at this time, based on this screening information and other information that may be warranted.

Health Care Provider, Title, Date Signed