Appendix 3. Integrated Tuberculosis (TB) Screening and Risk Assessment Form for Newly Hired HCP

Name: ________________________________ Date: ________________________________

Preferred Contact Information: ____________________________________________________________________________________

1. What position are you hired for? _______________ What is your start date? __________________

2. 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.
   a. YES I have been in a foreign country for ≥30 days (not including those listed above)
   b. NO I have not been in any country for ≥30 days except the ones listed above

3. Have you had close contact with anyone who had active TB since your last TB test? YES / NO

4. Do you currently have any of the following symptoms:
   a. YES / NO unexplained fever for more than 3 weeks
   b. YES / NO cough for more than 3 weeks with sputum production
   c. YES / NO bloody sputum
   d. YES / NO unintended weight loss >10 pounds
   e. YES / NO drenching night sweats
   f. YES / NO unexplained fatigue for more than 3 weeks

5. Have you ever been diagnosed with active TB disease? YES / NO

6. Have you ever been diagnosed with latent TB infection or had a positive skin test or a positive blood test for TB?
   a. YES one or more of these is true for me
   b. NO none of these is true for me

7. Have you been treated with medication for TB or for a positive TB test (eg, taken “INH”)?
   a. YES / NO
   If YES, what year, with which medication, for how long, and did you complete the treatment course?

8. 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 1 month, immune-suppressing medications such as a TNF-alpha antagonist or another immune-modulator? (If you are not sure, ask your Occupational Health provider)
   a. YES, one or more of these is true for me
   b. NO, none of these is true for me

____________________________________________________________________________________

Occupational Health Reviewer Signature ___________________________ Date ______________________