CROSS COUNTRY NURSES

Tuberculosis Assessment

Section A Tuberculosis Assessment (All clients must complete section "A".)

Have you had a Positive TB Exposure or Positive TB Skin Test History (PPD, QuantiFERON-TB-Gold, T-Spot, etc)?

❑ Yes ❑ No *(If **YES**, documentation required)* ***Symptom Review** to be completed **whether 'Yes' or 'No' to above***

1. Have you experienced any of the following symptoms in the past year?
   - A) A productive cough for more than 3 days? ❑ Yes ❑ No
   - B) Hemoptysis (coughing up blood)? ❑ Yes ❑ No
   - C) Unexplained weight loss? ❑ Yes ❑ No
   - D) Fever, Chills, or night sweats for no known reason? ❑ Yes ❑ No
   - E) Persistent shortness of breath? ❑ Yes ❑ No
   - F) Unexplained fatigue? ❑ Yes ❑ No
   - G) Chest Pain? ❑ Yes ❑ No
2. Have you had contact with anyone with active tuberculosis disease in the past year? ❑ Yes ❑ No
3. Do you have a medical condition, or are you taking medications, which suppress your immune system? ❑ Yes ❑ No

I have read and completed the signs and symptoms for Tuberculosis screening questions above. My answers are true to the best of my knowledge. If there are any changes in my health status related to TB signs and symptoms I will report them to the Company without delay. I realize that I must have clearance from my physician to return to work if I experience above signs/symptoms of active TB.

Client Name: _____ (PRINT) Client Signature: _____ (SIGNATURE) Date: _____ (MM/DD/YYYY)

Section B Tuberculosis Screening (Please attach all lab results / immunization records)

The following tests have been performed in my office/facility and under my supervision by medical personnel with training to place and read a PPD/Skin Test.

PPD/SKIN TEST

Placed: _____ (MM/DD/YYYY)

Time: ____:____ a.m. / p.m.

Manufacturer: _____

Exp Date: _____ (MM/DD/YYYY)

Lot #: _____

Read: _____ (MM/DD/YYYY)

Time: ____:____ a.m. / p.m.

Placed by: _____ (NAME) (SIGNATURE)

_____ (TITLE)

Office/Facility Name: _____

Address: _____

Telephone #: _____

Interpreted by: _____ (NAME) (SIGNATURE)

_____ (TITLE)

❑ Office/Facility Name is the same as above.

Office/Facility Name: _____

Address: _____

Telephone #: _____

RESULTS and/or

❑ Induration _____mm ❑ Negative ❑ Positive

BCG Immunization Date: _____ (MM/DD/YYYY)

QuantiFERON-TB-Gold Date: _____ (MM/DD/YYYY)

T-SPOT Date: _____ (MM/DD/YYYY)

Section C Tuberculosis History

Complete Section C only if there is a history of Positive TB Exposure.

Please provide most recent Chest X-ray radiology report.

❑ Positive TB Skin Test *(documentation required)* Date: _____ (MM/DD/YYYY)

Have you been treated with TB medication? ❑ Yes ❑ No

Treatment: ❑ INH ❑ Other

Chest X-Ray impression relative to positive PPD: ❑ Positive ❑ Negative Date _____ (MM/DD/YYYY)