TB SCREENING QUESTIONNAIRE

CLIENT:_____ **DOB:**_____ **ID No.:**_____
Last First

ARE YOU <u>COUGHING</u> FOR MORE THAN 3 WEEKS?	**YES**	**NO**
Have you recently <u>coughed up blood?</u>	**YES**	**NO**
Have you <u>lost more than 5 lbs</u> in the last 2 months?	**YES**	**NO**
Had <u>frequent fevers</u> in the last month?	**YES**	**NO**
Had <u>unusual sweating, especially at night?</u>	**YES**	**NO**

- If **"YES"** to *<u>cough</u>* ***and*** **"YES"** to *<u>one-or-more</u>* of the other TB symptom questions:
  See ***<u>TB SUSPECT</u>*** below.
- Other findings: Refer to medical provider, as needed, depending on the severity of symptoms.

HAVE YOU EVER HAD A TB SKIN TEST (TST)?	**YES**	**NO**
What was the result?	**Positive**	**Negative**
Do you have proof of your TST?	**YES**	**NO**

- **PREVIOUS TST DOCUMENTATION:** Record TST date and size:
- Copy TST document for program and client records.

TST Date	MM

SUMMARY (Check all applicable):

_____ **<u>TST Not Known/No Previous TST Done:</u>** Refer clients for TST ASAP (7 days max)

_____ **<u>TST Negative</u> (*<u>no documentation available</u>*):** Refer client for TST ASAP (7 days max)

_____ **<u>TST Negative</u> (*<u>documented as done within the last 3 months</u>*):** No TST needed now. Repeat TST yearly.

_____ **<u>TST Positive History</u> (*<u>no documentation</u>*):** Refer for an eval. of TST history ASAP (7 days max)

_____ **<u>TST Positive History</u> (<u>documented,</u> date and size recorded above):**

Chest x-ray needed within 7 days of admission UNLESS client presents documented proof of a normal x-ray done within the last 3 months. Copy x-ray report for clinic record and record date here.

X-ray date

_____ ***<u>TB SUSPECT</u>* (cough with one-or-more TB symptoms):** Contact TB Control to arrange immediate evaluation.

Staff completing this form: _____ **Date:** _____