the nurse agency

TB Screening

Employee Name: _____

Known previous positive reaction or history of tuberculosis? ☐ Yes ☐ No

If yes, a **Chest X-Ray** from the past *five years* is acceptable. Please **submit a copy** of the Chest X-Ray results and complete *The Nurse Agency Annual TB Questionnaire* form below.

Chest X-Ray Date: _____ Results: _____

Step 1
Manufacturer:_____ Lot #: _____ Exp. Date: _____

Date applied: _____ Date Read: _____ Results: _____ mm

Step 2
Manufacturer:_____ Lot #: _____ Exp. Date: _____

Date applied: _____ Date Read: _____ Results: _____ mm

Physician/Nurse Practitioner/Nurse:

Name: _____ Phone Number: _____

Address: _____

Signature: _____ Date: _____

TB Questionnaire

This form is part of the tuberculosis surveillance program. **Please complete this form annually if you have tested positive for TB.**

If you answer "**YES**" to any of the questions listed below please explain under the "**Comments**" section.

Yes	No	Question	Comments
		Cough or cold that won't go away?	
		Unexplained weight loss?	
		Night sweats?	
		Fever of unknown origin?	
		Shortness of breath?	
		Productive cough?	
		Bloody sputum?	

Signature: _____

Printed Name: _____

Date: _____

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