CONSUMER DIRECT CARE NETWORK

TUBERCULOSIS SYMPTOM SCREENING ANNUAL QUESTIONNAIRE

_____

DCW Printed Name

This form is required for any Direct Care Worker (DCW) who has received an X-ray examination to rule out active Tuberculosis (TB) infection. Please answer these questions with your health care professional (physician, nurse practitioner, etc.) and return the completed form to Consumer Direct.

Last TB Skin or Blood Test ____/____/_____

Last Chest X-Ray _____/____/_____

Have you been treated for TB or had a TB vaccination? ☐ Yes ☐ No

Explain: _____

Have you been in close contact with a person who has active TB? ☐ Yes ☐ No

Have you experienced any TB symptoms not associated with a specific illness (i.e. flu or cold)?

Chronic Cough (lasting more than 3 weeks)	☐ Yes	☐ No
Cough is Productive	☐ Yes	☐ No
Blood Streaked Sputum (phlegm)	☐ Yes	☐ No
Fever or Chills	☐ Yes	☐ No
Night Sweats	☐ Yes	☐ No
Unexplained Weight Loss	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No

Comments/Other symptoms discussed: _____

_____

Based on the above responses, I find this patient:

☐ Does not demonstrate symptoms of TB (additional chest x-ray not necessary)

☐ Demonstrates symptoms of TB (additional chest x-ray required)

_____

Healthcare Professional Printed Name

_____ _____

Healthcare Professional Signature Date

_____ _____

Clinic/Hospital Name Clinic/Hospital Phone Number

_____ _____

DCW Signature Date