Tuberculosis Symptom Screening Annual Questionnaire

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DCW 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 Care Network.

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: ____

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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)

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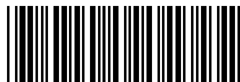
Healthcare Professional Printed Name

____ __________________
Healthcare Professional Signature Date

____ __________________
Clinic/Hospital Name Clinic/Hospital Phone Number

____ __________________
DCW Signature Date



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