

ANNUAL TUBERCULOSIS ASSESSMENT (For use with staff who are TST-positive)

Please complete the following brief questionnaire about your health.

Do you currently have any of the following symptoms?		
Yes	No	
		1. Cough lasting greater than two weeks?
		2. Unexplained weight loss?
		3. Loss of appetite?
		4. Unexplained fever?
		5. Night sweats?
		6. Blood tinged sputum production?
If yes to any question, please describe symptoms further. When did this start? Have you sought treatment? If yes, what treatment was done?		
Please answer the following questions:		
		1. Have you ever received BCG vaccine?
		2. What is your country of origin?
		3. Have you lived in any other country within the past 10 years?
		4. Have you been treated for TB?
Employee signature		Date
Infection Prevention/employee health nurse		Date
FOR OFFICE USE ONLY		
Was this employee referred for further evaluation?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, to whom?		
Chest x-ray?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Medication?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Work restrictions?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:		Date: