



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 Covenant 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 _____

