



Instructions:

- 1) Type name, Department, DOB & date below.
- 2) Date & Digitally Sign (/s/ then TYPE YOUR NAME Example: /s/John Doe) in the **Consent** section.
- 3) **ALL EMPLOYEES – with and without patient contact must complete the questionnaire.**
- 4) **Please save or print a copy for yourself prior to sending it to Employee Health.**
- 5) **If History of Positive TB Skin test – Review Signs/Symptoms – Then sign – Return form to Employee Health.**
- 6) If **Negative history, have TB Skin test done.** After it is read, return the completed form to Employee Health.

Employee Name	Department Name	DOB:	Date:
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Tuberculosis is a mycobacterial disease that is responsible for disability and death in many parts of the world. The CDC and Joint Commission recommend routine Tuberculosis screening of Healthcare Workers.

- The agent used for the TB skin test is an aqueous solution of a purified protein fraction isolated from culture filtrates of human type strains of mycobacterium tuberculosis.
- In highly sensitive individuals or those with prior positive tests, strong positive reactions including vesication, ulceration, necrosis or scarring may occur at the test site.

TB History and Respiratory System Review					
		NO	YES		
Do you have direct patient contact?				If no and no history of positive PPD, please sign, date and return to Employee Health.	
Have you ever had BCG vaccine (TB vaccine)?				When?	
Have you ever had a positive TB skin test?				Year first positive _____	
Have you had TB, the disease?				When?	
Were you treated with medication?				With what & how long?	
Have you ever had an allergic reaction to the PPD solution?				When?	
In the last 12 months, have any of the following occurred?					
TB Signs/Symptoms + reactors	NO	YES	For those using Respiratory Protection/N 95's/Fit tested EE's	NO	YES
Chronic cough (3 weeks or longer)?			Used a Face Mask (Isolation) at work? (if NO , STOP here, if YES , answer the following)		
Coughing up blood?			Had difficulty using the mask (respirator)?		
Chronic fatigue (tiredness)?			Grown facial hair? (new Mustache or Beard)		
Persistent night sweats?			Been fitted with dentures?		
Fever, chills?			Had a change in facial structure?		
Involuntary weight loss?			Gained or lost weight affecting facial size or shape?		
Are you being treated for a serious medical condition?			Developed a medical condition such as asthma, emphysema, bronchitis, fainting, shortness of breath, high blood pressure, diabetes, stroke?		
Are you taking Prednisone or chemotherapy?					
Explain YES response:					

CONSENT

I have read the above statement about TB skin testing and the special precautions. I have had the opportunity to ask questions and understand the benefits and risks of TB skin tests. I understand that, should I develop any of the above symptoms, I am to report to Employee Health Services immediately.

I understand TB testing and surveillance is a condition of employment with Central Maine Healthcare (CMHC). Failure to comply with the TB surveillance program can result in disciplinary action up to and including termination.

Employee Signature: _____ RN Signature: _____ Date: _____

Tspot	Date Drawn:	Date Result Rcvd:	Result:
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PPD						TB SKIN TEST			
Tubersol 0.1 ml ID		Given		Site	Given by	Read		Induration mm x mm	Read By
Lot #	Exp. Date	Date	Time			Date	Time		
								mm	

For PPD, read induration 48-72 hours after test applied/Record Induration as (number) mm.