665 Bay Rd, Unit D, Dover, DE 19901
phone (302) 678-1303 fax (302) 310-8852

800 N DuPont Blvd., Milford, DE 19963
phone (302) 430-5705 fax (302) 310-8852

18383 Hudson Rd, Milton, DE 19968
phone (302) 684-3812 fax (302) 310-8852

Patient Label

TUBERCULOSIS SCREENING

SECTION A: **Patient Name (*PLEASE PRINT*)**:_____ **DOB**:_____ **Employee #**:_____

Select type of screening:

□ Baseline/Pre-Placement □ Annual □ Post TB Exposure (baseline) □ Post TB Exposure (8-10 week follow up)

TB Risk Assessment Questions:

1. Have you ever lived or had temporary or permanent residence for more than 30 days in a high TB rate country? □ No □ Yes
   (*any country other than the United States, Canada, Australia, New Zealand, and Northern/Western Europe*)
2. Are you currently or plan to become immunosuppressed (*see explanation below*)? □ No □ Yes
   (this includes human immunodeficiency (HIV) infection, organ transplant recipient, treatment with a TNF antagonist (e.g., infliximab, etanercept, or other) chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication)
3. Have you ever had a positive TST/PPD, Mantoux TB skin test, or IGRA blood test (*T-Spot or QuantiFERON Gold*)? □ No □ Yes

   If YES – can you provide documentation of the positive test result? □ No □ Yes

   If YES – Which test was positive? □ PPD Skin Test □ T-Spot □ QuantiFERON Gold □ Unsure of test

   Was testing completed at a Bayhealth Medical Center facility? □ Yes: Date:_____ □ No: State completed in:_____
4. Have you ever been vaccinated with the BCG vaccine (*Bacillus Calmette–Guérin*)? □ No □ Yes

   Approximate date of BCG vaccination: _____ □ Unsure of date
5. Have you ever had treatment for TB? □ No □ Yes – State: _____ Year:_____
6. Have you had close contact with someone who has infectious TB disease since your last TB test? □ No □ Yes

TB Symptom Evaluation:

Have you had any of the following?

1. a bad cough lasting 3 weeks or longer	□ No	□ Yes
2. pain in your chest	□ No	□ Yes
3. coughing up sputum (*phlegm from deep inside the lungs*) or blood	□ No	□ Yes
4. weakness or fatigue	□ No	□ Yes
5. weight loss	□ No	□ Yes
6. no appetite	□ No	□ Yes
7. chills	□ No	□ Yes
8. fever	□ No	□ Yes
9. sweating at night	□ No	□ Yes

I attest the above responses are accurate to the best of my knowledge. I understand that I may be contacted by Occupational Health to further discuss Risk Assessment Questions and Symptoms to determine if additional testing will be required (such as IGRA blood draw or x-ray).

_____ _____/_____/_____ ____:____ AM / PM (_____)_____-_____

Patient Signature **Date** **Time** **Contact Number**

SECTION B: *OCCUPATIONAL HEALTH ONLY* *Clinical staff to sign only if there are no "yes" answers*

_____ _____/_____/_____ ____:____ **AM / PM**

Occupational Health Signature **Date** **Time**

Original: Occupational Health Yellow Copy: Employee

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Patient Label

TUBERCULOSIS SCREENING

Patient Name (*PLEASE PRINT*):_____ **DOB:**_____ **Employee #:**_____ **Dept:**_____

PPD Skin Tests must be read within 48-72 hours of time it was placed or PPD must be repeated (at cost of employee)
Results can be e-mailed to: Occupational_Health@Bayhealth.org **or** faxed to (302) 310-8851
Please keep a copy of PPD results for your own records.

OCCUPATIONAL HEALTH ONLY

TB Testing:

PPD 1 Date: _____ **Time Placed:** _____**AM/PM**
Placed by: _____
Lot#_____ **Exp. Date:**_____
Site: □ **RT arm** □ **LT arm**

PPD Read Date: _____ **Time Read:**_____ **AM/PM**
PPD 1 result: _____**mm** □ **Negative** □ **Positive**

Read by:_____ □ **Occ Health**
Phone Number: _____ **Dept:**_____

PPD 2 Date: _____ **Time Placed:** _____**AM/PM**
Placed by: _____
Lot#_____ **Exp. Date:**_____
Site: □ **RT arm** □ **LT arm**

PPD Read Date: _____ **Time Read:**_____ **AM/PM**
PPD 2 result: _____**mm** □ **Negative** □ **Positive**

Read by:_____ □ **Occ Health**
Phone Number: _____ **Dept:**_____

IGRA Blood Draw*: (preferred testing for BCG vaccine history)*

□ T-Spot	Date:_____	Result:_____
	Date:_____	Result:_____
□ Quantiferon Gold	Date:_____	Result:_____
	Date:_____	Result:_____

Chest X-Ray:

Date of Exam:_____
Results: □ Chest X-ray is negative
□ Chest X-ray is abnormal

TB Screening Results: (*check all that apply*)

□ TB Screening negative

□ TB Screening positive:

- □ Chest X-ray recommended
- □ IGRA recommended

□ TB Screening positive

- □ Chest X-Ray results pending
- □ IGRA Results pending

□ Referred to State TB Clinic or Infectious Disease Specialist for TB evaluation and/or treatment

□ Clear to work

□ Not clear to work

_____ _____/_____/_____ ____:____ **AM / PM**
Occupational Health Signature **Date** **Time**