

# UNIVERSITY OF MIAMI, EMPLOYEE HEALTH TUBERCULOSIS SCREENING & TESTING FORM

Print last name, first, middle initial	Date of birth	Social Security #
Department	Work phone #	Supervisor
Work location (building & room)	Home address	Telephone #

1. Have you ever tested positive for TB? \_\_\_\_\_ When? \_\_\_\_\_
2. Have you ever taken medications for TB? \_\_\_\_\_
3. In what Country were you born? \_\_\_\_\_
4. BCG is a vaccine for TB. Were you BCG vaccinated? \_\_\_\_\_ When? \_\_\_\_\_
5. Do you have direct contact with Patients? \_\_\_\_\_
6. Do you have a weak immune system? \_\_\_\_\_
7. Have you had a chest xray in the past two years? \_\_\_\_\_
8. Was it normal? \_\_\_\_\_

9. Do you have any of the following symptoms?
- |   |           |          |
|---|-----------|----------|
| Persistent cough (greater than two weeks) | Yes _____ | No _____ |
| Unexplained weight loss . . . . .         | Yes _____ | No _____ |
| Unexplained loss of appetite . . . . .    | Yes _____ | No _____ |
| Frequent low-grade fevers . . . . .       | Yes _____ | No _____ |
| Night sweats . . . . .                    | Yes _____ | No _____ |
| Frequent chills . . . . .                 | Yes _____ | No _____ |
| Frequent fatigue . . . . .                | Yes _____ | No _____ |

10. Allergies: \_\_\_\_\_
11. \_\_\_\_\_ I consent to be tested for tuberculosis. I will return at the designated time to have the test read. I understand that failure to return may result in disciplinary action.
12. \_\_\_\_\_ I decline to be tested secondary to a previous positive skin test. I understand I may be required to obtain a chest xray at no expense to myself.
13. Do you have animal contact at work?                      Yes \_\_\_\_\_      No \_\_\_\_\_

14. Employee signature \_\_\_\_\_ Date \_\_\_\_\_

**Do not write below this line**

Date Placed \_\_\_\_\_ Results \_\_\_\_\_ Induration \_\_\_\_\_ Chest Xray Ordered \_\_\_\_\_

Angery Testing \_\_\_\_\_ XrayResults \_\_\_\_\_

Medication prescribed \_\_\_\_\_

(2- Step testing)  Yes  No PPD - Lot # \_\_\_\_\_ Manufacturer Connaught exp. date \_\_\_\_\_

Dose (0.1-ml Route - Intradermally  \_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_

Is this result considered a conversion \_\_\_\_\_

\_\_\_\_\_

Health Care Provider signature \_\_\_\_\_ Date \_\_\_\_\_