

Nananom Assisted Living
210 E. Hunter Dr. Globe, AZ 85501

Tuberculosis (TB) Screening and Risk Assessment Form for Newly Hired HCP

Name: _____

Date: _____

Preferred Contact Information: _____

1. What position are you hired for? _____ What is your start date? _____
2. Have you EVER spent more than 30 days in a country with an elevated TB rate? This includes all countries except those in Western Europe, Northern Europe, Canada, Australia, and New Zealand.
___ YES I have been in a foreign country for ≥ 30 days (**not including those listed above**)
___ NO I have not been in any country for ≥ 30 days **except the ones listed above**
3. Have you had close contact with anyone who had active TB since your last TB test?
Circle that applies YES / NO
4. Do you currently have any of the following symptoms: **Circle that applies**
 - a. YES / NO unexplained fever for more than 3 weeks
 - b. YES / NO cough for more than 3 weeks with sputum production
 - c. YES / NO bloody sputum
 - d. YES / NO unintended weight loss > 10 pounds
 - e. YES / NO drenching night sweats
 - f. YES / NO unexplained fatigue for more than 3 weeks
5. Have you ever been diagnosed with active TB disease? **Circle that applies**
YES / NO
6. Have you ever been diagnosed with latent TB infection *or* had a positive skin test *or* a positive blood test for TB? **Check that applies**
___ YES one or more of these is true for me
___ NO none of these is true for me
7. Have you been treated with medication for TB *or* for a positive TB test (eg, taken "INH")?
Circle that applies YES / NO
If YES, what year, with which medication, for how long, and did you complete the treatment course?

8. Do you have a weakened immune system for any reason including organ transplant, recent chemotherapy, poorly controlled diabetes, HIV infection, cancer, or treatment with steroids for more than 1 month, immune-suppressing medications such as a TNF-alpha antagonist or another immune-modulator? (If you are not sure, ask your Occupational Health provider) **Circle that applies**
___ YES, one or more of these is true for me
___ NO, none of these is true for me

Occupational Health Reviewer Signature

Date