ONYX
HEALTH CARE STAFFING

Tuberculosis Skin Test Administration Record

Associate Name: _____ Last 4 Digits of SSN: _____

1. Have you had a TB Skin Test in the past? ❑ Yes ❑ No

2. Have you ever had a positive TB Skin Test in the past or been told not to have a TB skin test? ❑ Yes ❑ No

3. Have you received the BCG Vaccination? ❑ Yes ❑ No
   a. If yes, have you had subsequent TB Skin Tests? ❑ Yes ❑ No

4. Have you had any symptomology to suggest tuberculosis? (Persistent cough, low grade fever/chills, unexplained loss of appetite, recent weight loss, night sweats, increased fatigue, shortness of breath, coughing up blood, chest pain? ❑ Yes ❑ No
   a. If yes, please explain:
   _____
   _____

Please Note: An individual may not respond to a TB skin test (even with TB exposure) if he/she has had a recent bacterial or viral infection, is taking any immunosuppressive drugs such as corticosteroids, has had any recent 'live' immunizations or has overwhelming tuberculosis disease. It is your responsibility to alert the staff if any of these pertain to you.

Additional Comments: _____

I understand that according to policy/procedure and/or state regulations for healthcare workers, annual testing for Tuberculosis is required. I agree to the administration of a TB skin test. I further release the organization from any liability for any complications which may arise due to the skin testing. Furthermore, I understand that the TB Skin Test must be read within 48-72 hours after placement or it will have to be repeated.

X _____ *Date:* _____

Date & Time of TST: _____ Site: _____ Given by _____

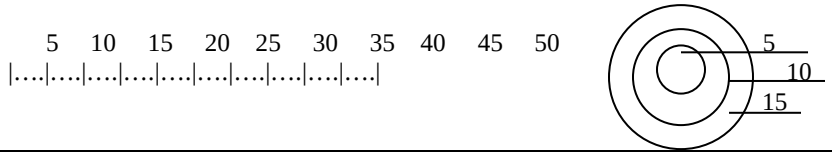
Lot# _____ Exp. Date _____ Manufacturer _____

TB skin test is to be read on: Sun. M. Tu. W. Th. F. Sat.
Time test to be read: _____
_____

Date/Time Read _____ Induration mm _____ ❑ Negative ❑ Positive

Read by _____ Signature _____ Title _____

ANY POSITIVE RESULT MUST BE REPORTED TO THE DEPARTMENT OF HEALTH.



TUBERCULOSIS (TB) Questionnaire and Annual Surveillance

This is intended for those who have had a positive skin test result. Since you are no longer required to have an annual Chest X-Ray (CXR), the following is to be completed annually and maintained in the personnel file. However, you must have the results of at least one CXR on file.

Facility/Medical Office Name: _____
Full Address: _____
Office Phone Number: _____
Patient Name: _____

To assess whether or not you may need to have a chest x-ray at this time, please answer the following questions

Have you been experiencing any of the following?

1. Persistent cough? _____ Yes _____ No
2. Low grade fever/chills? _____ Yes _____ No
3. Unexplained loss of appetite? _____ Yes _____ No
4. Recent weight loss? _____ Yes _____ No
5. Night sweats? _____ Yes _____ No
6. Increased fatigue? _____ Yes _____ No
7. Shortness of breath? _____ Yes _____ No
8. Coughing up blood? _____ Yes _____ No
9. Chest pain? _____ Yes _____ No

Note: If you should experience any of the above symptoms, you must notify Source One immediately.

To Be Completed by Physician or Nurse Practitioner:

Positive TB History: _____ Yes _____ No

Chest X-Ray on record: _____ Yes _____ No

If yes, give date: _____ Results: _____

Prophylactic Treatment: _____ Yes _____ No

Active TB Diagnosis? _____ Yes _____ No

Based on above assessment, is CXR indicated?:_____ Yes _____ No *(If yes, must provide copy of CXR for personnel file.)*

_____ _____
MD/NP Printed Name Date

_____ _____
MD/NP Signature License Number