McLaren Business Products

McLaren Print System Order

Order No: 48643
Order Date: 2019-09-16
User: Lori Pidick
Phone: 810-989-3320

Ship Location: McLaren Port Huron
1221 Pine Grove Avenue
Port Huron, MI 48060
Forms
Quantity: 1000
Paragon Dept No: 8265
Dept Name: Materials Management
Company Number: 480

Order Total Price: 160.00

Item Number: PH-22
Item Description: TB Test Form 2019
Revision Date: 9/2019
Print:
Paper:
Size:
Fold:
Finish:
Drill:
Misc Info: 2 Part NCR; black

PORT HURON

TB TEST / QUESTIONNAIRE

Name: ______________________ Department: ______________________

1st step: ______ 2nd Step: ______ Other ____________

Complete the following:
Ever been told you had Tb? ____Yes ____No
Ever lived with anyone with Tb? ____Yes ____No
Ever had a positive Tb test? ____Yes ____No
Taken Tb medications after a positive Tb test? ____Yes ____No
Received an MMR or any live vaccine in the past 4-6 weeks? ____Yes ____No
Received a BCG vaccination in the past 5 years? ____Yes ____No

Temporary or permanent residence (for 1 month or longer) in a country with high TB rate (i.e. any country other than Australia, Canada, New Zealand, USA, or western or northern Europe)? ____Yes ____No

Have you current or planned immunosuppression, including HIV virus infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist (e. g. infliximab or etanercept) chronic steroids (prednisone 15mg/ day over one month) or other immunosuppressive medication? ____Yes ____No

Close contact with someone that has had infectious TB disease since last TB test? ____Yes ____No

Productive cough (3 weeks or more) ____Yes ____No
Persistent weight loss without dieting ____Yes ____No
Persistent low-grade fever ____Yes ____No
Night sweats ____Yes ____No
Unexplained loss of appetite ____Yes ____No
Coughing up blood ____Yes ____No

By signing below, I am agreeing to the following statements:
- To the best of my knowledge, I have answered all the above correctly.
- I understand I need to have my test read in **48-72 hours** by EHS, a nurse or a physician.
- Questionable TB results - Employee Health Services must read/review.

Signature: ______________________ Date: ______________

Date Administered __________ **Time**: __________ **Site**: ______ **Title**: ______________

Dose 0.1 **Manufacturer**: ______________ **Lot #** ______________ **Exp Date**: ______________

Read on: Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Results: ________ **mm** (Read induration, not erythema)

Date read: ____________ **Time** __________ **Read By/Title**: ______________

Follow Up Recommendation: Chest X-Ray Date: ______________ Results: ______________

Return form to Human Resources or fax to [illegible]. Any questions call [illegible].
[illegible]

Spec Info: