

McLaren Print System Order

Order No: 60343 Reprint Previous Order No: 5562
 Order Date: 2021-02-17
 User: Cindy Simpson
 Phone: 8104960900

Ship Location: **MCLAREN OCCUPATIONAL AND CONVENIENT CARE ATTN CINDY**
 2313 East Hill Road
 Grand Blanc, MI 48439

Forms

Quantity: 100
 Paragon Dept No: 64100
 Dept Name: McLaren Occupational and Convenient Care
 Company Number: 810

Order Total Price: 11.80

Item Number: MM-34078
 Item Description: TB Screening Questionnaire
 Revision Date: 8/2013
 Print: 1 sided black and white
 Paper: 2 Part (White, Yellow)
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill: None
 Misc Info:

McLaren Medical Group
TB Screening Questionnaire

Employee Use Only:
 Dept: _____
 New Hire Semi-Annual Annual Post Positive Questionnaire
 Post Exposure Date: __/__/__

Please read and answer the following questions very carefully.

- Have you ever been told you had TB? Yes No
- Have you ever lived with anyone with TB? Yes No
- Have you had close contact with a person with TB? Yes No
- Have you ever had a positive TB test? Yes No
- Have you taken TB medications after a positive TB test? Yes No
- Have you received a live shot vaccine in the past 4-6 weeks? Yes No
- Were you born outside of the United States? Yes No
- Have you traveled outside of the United States (other than Canada, New Zealand, Western Europe or Australia)? Yes No
- Have you ever received BCG vaccinations? Yes No
- Have you ever lived in a long term care, correctional facility, or shelter? Yes No
- Have you had close contact with someone who was in a Long Term Care Facility, Correctional Facility or Shelter within the last 5 years? Yes No
- Have you ever injected illicit drugs? Yes No
- Are you frequently exposed to anyone who injects illicit drugs? Yes No
- Are you frequently exposed to migrant farm workers? Yes No
- Have you had contact with anyone coming from a foreign country? Yes No
- Have you had a recent anal infection? Yes No

Please check if you have any of these symptoms (symptoms of TB) and DO NOT know the cause:
 Cough with sputum or blood for more than 2 weeks Night sweats Shortness of breath
 Unexplained weight loss/Appetite loss Fever/Chills Fatigue Chest pain

Please check if you have the following health problems or are taking any of these medications:
 Any immune-compromising conditions Currently taking steroids
 Currently taking Chemotherapy HIV positive or at risk for HIV

By signing in the space below, I am agreeing to the following statements:
 > To the best of my knowledge, I have answered all of the above questions correctly
 > I understand the TB screening program and need to have my test read in 48 to 72 hours. If I do not return within 72 hours, I will need to have the test re-done.
 > (For employees only) I agree to inform the Employee Health Nurse, if I develop any symptoms of TB before my next TB screening.

Patient/Employee/Parent Signature: _____ Date: _____

Physician Signature: _____ Date/Time: _____

- Risk Evaluation:**
 Test immediately
 Test immediately and annually while risk exists
 Begin treatment
 No risk, no testing needed

Physician Name: _____
 Date of Exam: _____