

McLaren Print System Order

Order No: 61682 Reprint Previous Order No: 5562
Order Date: 2021-04-13
User: Cindy Simpson
Phone: 8104960900

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

Forms

Quantity: 500
Paragon Dept No: 64100
Dept Name: McLaren Occupational and Convenient Care
Company Number: 810

Order Total Price: 59.00

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?
Have you ever lived with anyone with TB?
Have you had close contact with a person with TB?
Have you ever had a positive TB test?
Have you taken TB medications after a positive TB test?
Have you received a live shot vaccine in the past 4-6 weeks?
Were you born outside of the United States?
Have you traveled outside of the United States (other than Canada, New Zealand, Western Europe or Australia)?
Have you ever received BCG vaccinations?
Have you ever lived in a long term care, correctional facility, or shelter?
Have you had close contact with someone who was in a Long Term Care Facility, Correctional Facility or Shelter within the last 5 years?
Have you ever injected illicit drugs?
Are you frequently exposed to anyone who injects illicit drugs?
Are you frequently exposed to migrant farm workers?
Have you had contact with anyone coming from a foreign country?
Have you had a recent anal infection?

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

Print Name:
Date of Birth: