

McLaren Print System Order

Order No: 41886 Reprint Previous Order No: 5562
 Order Date: 2019-01-11
 User: Jessica Smith
 Phone: 989-773-1166

Ship Location: McLaren Central ReadyCare/ attn: Jessica
 1523 S. Mission St.
 Mt. Pleasant , Mi 48858

Forms

Quantity: 500
 Paragon Dept No: 75400
 Dept Name: Central ReadyCare
 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? 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.

Patent/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

Patient Name: _____
 Date of Birth: _____