McLaren Business Products

McLaren Print System Order

Order No: 8630 Reprint Previous Order No: 5562
Order Date: 2015-01-30
User: Denise Turner
Phone: 810 342-1711

Ship Location: Denise Turner
1314 S. Linden Rd., Suite B
Flint, MI 48532
Forms
Quantity: 500
Paragon Dept No: 63550
Dept Name: McLaren-Flint Community Medical Center
Company Number: 810

Order Total Price: 59.75

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: 5 Hole Top
Misc Info:

McLaren Medical Group

TB Screening Questionnaire

Employee Use Only:
Dept: _____
☐New Hire ☐Semi-Annual ☐Annual ☐Past 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 virus 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 anyone who has HIV (AIDS virus)?	☐ Yes	☐ No
Are you frequently exposed to migrant farm workers?	☐ Yes	☐ No
Have you had contact with anyone visiting from a foreign country?	☐ Yes	☐ No
Have you had a recent viral infection?	☐ Yes	☐ No

Please check if you have any of these symptoms (symptoms of TB) and DO NOT know the cause:
☐ Cough w/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 risks exists
☐ Begin treatment
☐ No risk, no testing needed

Patient Name

Date of Birth