McLaren Business Products

McLaren Print System Order

Order No: 81620 Reprint Previous Order No: 5562
Order Date: 2023-12-12
User: Amber Kleekamp
Phone: 9895519951

Ship Location: McLaren Thumb Convenient Care Clinic
1040 S. Van Dyke
Bad Axe, MI 48413
Forms
Quantity: 1000
Paragon Dept No: 54604
Dept Name: McLaren Thumb Convenient Care Clinic
Company Number: 810

Order Total Price: 113.00

Item Number: MM-34078
Item Description: TB Screening Questionnaire
Revision Date: 11/2023
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: _____

❑ **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 had close contact during your lifetime with someone who has had infectious TB disease?	❑ Yes	❑ No
Have you had close contact with a person with TB?	❑ Yes	❑ No
Have you ever had a positive TB test?	❑ Yes	❑ No
If yes, 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
Have you had a temporary or permanent residence of ≥1 month in a country with a high TB rate. (Any country other than the United States, Canada, Australia, New Zealand, and those in northern Europe or western Europe).	❑ Yes	❑ No
Have you ever received BCG vaccinations?	❑ Yes	❑ No
Have you ever injected illicit drugs?	❑ Yes	❑ No
Are you frequently exposed to anyone who injects illicit drugs?	❑ 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

❑ Chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month)

❑ 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.

Patient/Parent Signature: _____ Date: _____

Provider 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: