

McLaren Print System Order

Order No: 86909
Order Date: 2024-07-12
User: Kristal Johnson
Phone: 810-487-3601

Ship Location: Flushing CMC
2487 N Elms Rd
Flushing MI,48433

Brochures
Quantity: 500
Paragon Dept No: 50011
Dept Name: Flushing CMC
Company Number: MMG20

Order Total Price: 7.65

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: Padded (100 Sheets Per Pad)
Drill: None
Poster:
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:

- Spec Info: • 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: _____