

**McLaren Print System Order**

**Order No: 87838**  
**Order Date: 2024-09-03**  
**Order Request Date:**  
**User: Teresa Wenzlick**  
**Phone: 9897795692**

**Ship Location: McLaren Comp and Readycare - Attn: Jennifer Wheeler**  
**1523 S Mission St**  
**Mt. Pleasant, MI 48858**

**Brochures**  
**Quantity: 500**  
**Paragon Dept No: 55802**  
**Dept Name: Mt. Pleasant**  
**Company Number:**

**Order Total Price: 59.00**

**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**  
**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  $\geq 1$  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  $\geq 15$  mg/day for  $\geq 1$  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: \_\_\_\_\_

Spec Info:

**Risk Evaluation:**

- Test immediately  
 Test immediately and annually while risks exists.  
 Begin treatment  
 No risk, no testing needed

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_