TUBERCULOSIS (TB) RISK ASSESSMENT AND ATTESTATION SCREENING FORM

Full Name: _____	Date: _____/_____/_____ Month Day Year
Positive TB Skin Test (PPD): Date: _____/_____/_____ Month Day Year Result/Induration: _____	Last Chest X-Ray Date: _____/_____/_____ Month Day Year
Please indicate if you are having the following problems:	
1) Chronic Cough ≥ three (3) week duration	Yes ☐ No ☐
AND	
2) At least one (1) of the following:	
a. Fever	Yes ☐ No ☐
b. Night Sweats	Yes ☐ No ☐
c. Unintentional Weight Loss > 10% of Body Weight	Yes ☐ No ☐
d. Blood-Streaked Sputum	Yes ☐ No ☐
e. Fatigue/Tiredness	Yes ☐ No ☐
3) Anything other than the above? If, "Yes," describe the problem: _____ _____ _____	Yes ☐ No ☐

Note: If pulmonary TB symptoms are present, a standard chest x-ray is required.

For MD/APRN Use

☐ **NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM**

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Print Name of MD/APRN: _____

MD/APRN Signature: _____

Date: _____/_____/_____ Month Day Year