Annual Tuberculosis Symptom Screen

Employee Name: _____

- ☐ A previous positive tuberculin skin test (TST) has been documented.
- ☐ A chest radiograph was conducted to rule out active TB.
- ☐ HCW has received treatment for latent TB infection (LTBI).

All documentation pertaining to the healthcare workers test results, diagnosis and any referrals for medical follow-up are maintained in the employee's medical record. The HCWs privacy will be maintained according to all federal regulations.

To be completed by the healthcare worker:

Have you experienced any of the following symptoms in the last twelve months:

- ☐ fever
- ☐ night sweats
- ☐ unexplained weight loss
- ☐ hoarseness
- ☐ fatigue
- ☐ chest pain
- ☐ bloody sputum
- ☐ persistent cough, lasting two or more weeks

I understand that to prevent transmission of M. tuberculosis to fellow HCWs or patients that I must immediately report any of the above symptoms suggestive of infectious TB disease to my supervisor or the Safety Training Coordinator so that further diagnostic testing and/or medical follow-up can be conducted.

_____
Employee Signature

_____
Date