Elite | Care Management Care at Home
ILLINOIS · INDIANA · FLORIDA
Complete Home Care Services

ANNUAL SYMPTOM TB SCREENING

Employee Name: _____ Date of Birth:_____

Do you currently have any of the following symptoms?

Cough lasting more than 3 weeks, unexplained?	☐Yes	☐No
Hemoptysis (coughing up blood)	☐Yes	☐No
Fever or chills, unexplained?	☐Yes	☐No
Night sweats (sweating that leaves the bedclothes and sheets wet)?	☐Yes	☐No
Persistent shortness of breath, unexplained?	☐Yes	☐No
Chest pain, unexplained?	☐Yes	☐No
Weight loss, unexplained?	☐Yes	☐No
Fatigue, (feeling very tired) for no reason?	☐Yes	☐No
Have you had contact with anyone with active TB disease in the past year?	☐Yes	☐No
Do you have a medical condition or are you taking medications, which suppresses your immune system?	☐Yes	☐No

Please provide details to any question answered "Yes"

_____

_____

_____

***The above health statement is accurate to the best of my knowledge. I will contact my health care professional and/or the health department if my health changes.**

Employee Signature: _____Date: _____

Upon review of the responses to the questionnaire and discussion with the person for whom the tuberculosis evaluation is required, I recommend as follows:

_____There is no indication this person has active tuberculosis currently.

_____ Further evaluation, including a TB Skin Test or other medical evaluation is indicated.

Healthcare Professional Signature: _____Date: _____