

OCCUPATIONAL HEALTH Tb (Tuberculosis) Screening DOCUMENTATION FORM
 Edward Hines, Jr. VA Hospital 5000 S. 5th Avenue, Hines, IL 60141
 Occupational Health, Building 1, Section E, Room 147- Phone 708.202.2186 - Fax 708.202.2310

 VOLUNTEER/EMPLOYEE NAME

 ADDRESS

 CITY, STATE & ZIP CODE

 E-MAIL ADDRESS

 SS# (last four) DATE

 DAYTIME PHONE WITH AREA CODE

 DATE OF BIRTH SEX

EMPLOYEE ADULT VOLUNTEER STUDENT VOLUNTEER

Employees/Volunteers are **REQUIRED** to be screened for tuberculosis (Tb) prior to your start date. If available, please provide documentation of previous Tb testing documentation. If you have a history of a positive Tb skin test, you may be sent for a blood test and/or receive a chest x-ray unless proper evidence of Tb screening is presented. In addition, for those with a positive screening history please review the symptoms of Tb highlighted in the last paragraph and sign below.

Please bring this form to Occupational Health (see above) on Mondays, Tuesdays, Wednesdays or Fridays (**not on Thursdays**) between **8 a.m. to/and PRIOR to 3:30 p.m.** for the test. Please anticipate 2 or more additional visits for evaluation and administration with the dates to be determined. If you fail to return for the reading, you may need to have the test repeated.

*******INFORMATION BELOW TO BE COMPLETED BY EHS MEDICAL PERSONNEL*******

- NKDA Allergy (To be performed 1-3 weeks after first test and only if first test is negative/not positive)
 - No Hx of +TST No Immuno/Medical Compromise
 - No Hx of Latex sensitivity/allergy
- If yes, reviewed latex form _____ (initial)

TEST #1

TEST #2

Administration Date: _____ CPRS <input type="checkbox"/> Lot #: _____ Exp. _____ Mfr. _____ 0.10cc L or R forearm ID (circle L or R)	Administration Date: _____ CPRS <input type="checkbox"/> Lot #: _____ Exp. _____ Mfr. _____ 0.10cc L or R forearm ID (circle L or R)
Titled Signature: _____	Titled Signature: _____
Date Test Read: _____ CPRS <input type="checkbox"/> Result: Negative: _____ (_____) mm of induration Not Positive: _____ (_____) mm of induration Positive: _____ (_____) mm of induration Indeterminate: _____	Date Test Read: _____ CPRS <input type="checkbox"/> Result: Negative: _____ (_____) mm of induration Not Positive: _____ (_____) mm of induration Positive: _____ (_____) mm of induration Indeterminate: _____
Titled Signature: _____	Titled Signature: _____

Quantiferon T-spot Test ordered/reviewed (circle one) Date: _____ Result: _____ If positive, will need chest x-ray ** POSITIVE results/history of the following tests will Require a chest x-ray: ✓ TST ✓ Quantiferon ✓ T-spot Test	Results Reviewed Titled Signature _____ Chest x-ray Date: _____ Chest x-ray Results _____ Results Reviewed Titled Signature _____
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*******FOR THOSE WITH A POSITIVE TB SKIN TEST HISTORY*******

If you have had a positive Tb screening in the past and are NOT experiencing any Tb symptoms **such as persistent cough, night sweats, coughing up blood, malaise or weight loss**, please sign below.

Signature: _____ Date: _____

FOR OHS PERSONNEL ONLY: Clearance Form to Voluntary Services via VOLUNTEER or I/O MAIL