

VOLUNTEER BETHEL HEALTH CARE CENTER TB (PPD) TEST QUESTIONNAIRE

Name: _____

Position: _____

Date of Birth: _____

Volunteer Signature: _____ Date: _____

Parent/Guardian Consent if a minor: _____

NOTE: If a health practitioner has told you that your immune system is suppressed or compromised, please notify the person administering the TB test. Some medical conditions may cause a TB skin test to be negative even when TB infection is present.

- | | | |
|--|------------------------------|-----------------------------|
| 1. Were you born in the United States? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you ever received the BCG vaccine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| o If 'Yes', in what year was your most recent BCG vaccine? _____ | | |
| 3. Have you had a positive PPD in the past? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you answered 'No,' to question 1 or 'Yes' to questions 2 or 3, then Quantiferon blood test will be administered; if positive, Chest X-ray will be done.

 o ***Quantiferon done on _____; Chest X-ray done on _____***

- | | | |
|---|------------------------------|-----------------------------|
| 4. Have you traveled overseas in the past year? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Have you had exposure to a known case of TB in the past year? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Have you ever had any of the following symptoms for more than three weeks at a time? | | |
| o Excessive sweating at night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| o Persistent coughing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| o Excessive fatigue? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| o Coughing up blood? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| o Unexplained weight loss? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Individuals with a positive PPD: If your new PPD is positive, the Quantiferon blood test will be administered; if positive, a chest X-ray will be done.

Documentation of INH therapy: _____

1st Step PPD

Date Administered: _____		By: _____		Title: _____	
Site: <input type="checkbox"/> RA	<input type="checkbox"/> LA	Lot #: _____	Exp. Date: _____		
Date Read: _____		mm induration: _____			
By: _____			Title: _____		