

Name _____

F. TUBERCULOSIS EXPOSURE SCREENING¹/RISK ASSESSMENT

NURSING STUDENTS: PLEASE CHECK THE BOX BELOW INDICATING YOUR YEAR AND TRACK

SOPHOMORE A B C

JUNIOR A B C

SENIOR A B C

*MARK "A" IF YOU ARE ON TRACK, IF YOU ARE UNSURE OF YOUR TRACK CONTACT PAULA HARROLD 277-7158

1. Do you have signs or symptoms of active TB disease?

YES NO

- 1) Productive cough (3 weeks +)
- 2) Persistent unexplained weight loss
- 3) Persistent low grade fever
- 4) Night sweats
- 5) Loss of appetite
- 6) Swollen glands, usually in the neck
- 7) Coughing up blood

YES NO

- 8) Shortness of breath
- 9) Fatigue, weakness, feeling rundown
- 10) Chest pain
- 11) Chills
- 12) Exposure to a known case of TB
- 13) Hoarseness

If YES to any of these, proceed with additional evaluation to exclude active TB disease. This may include tuberculin skin testing, chest x-ray, and sputum evaluation as indicated. Please contact your own personal physician or call the T.B. Control Clinic at (414) 285-8630.

2. Tuberculin Skin Test: (Please send documentation of all testing done outside of MSOE)

Date Given: / / Date Read: / / Result mm Positive Negative
MM DD YY MM DD YY

 / / / / Result mm Positive Negative
MM DD YY MM DD YY

 / / / / Result mm Positive Negative
MM DD YY MM DD YY

 / / / / Result mm Positive Negative
MM DD YY MM DD YY

Interpretation based on millimeters of induration as well as risk factors.

3. Have you ever had treatment for a positive TB Skin Test? Yes No

If yes, date and type of preventative therapy: _____

Was therapy completed? (If no, explain): _____

Date of last chest x-ray: / / Result: _____
MM DD YY

Ongoing frequency of Chest x-ray recommended by my physician: _____