Jefferson University Hospitals

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Mandatory Tuberculosis Screen

Select reason: ☐ PRE-EMPLOYMENT ☐ PRE-MATRICULATION ☐ PRE-PLACEMENT (Volunteer) ☐ EXPOSURE ☐ ANNUAL

Select your role: ☐ VOL. FACULTY ☐ MED STAFF ☐ EMPLOYEE (HOUSE STAFF) ☐ VOLUNTEER ☐ STUDENT

Students, select your program: ☐ JMC ☐ JSN ☐ JSHP ☐ JGSBS ☐ JSPH ☐ JSP

First Name (Print name as it appears on your passport.) Last Name

Date of Birth (M M – D D – Y Y) Cell Number (– – –)

PPD # 1 – FOR PROVIDER USE ONLY

Date of placement: ____/____/____ Placed by: _____ ☐ L arm ☐ R arm

PPD to be read: ____/____/____ Manufacturer: _____ Lot #: _____ Exp. Date: _____

RESULTS: Reading date: ____/____/____ MM of Induration: _____ mm Read by: _____

PPD # 2 – FOR PROVIDER USE ONLY - PPD #2 Due Date: ____/____/____

Date of placement: ____/____/____ Placed by: _____ ☐ L arm ☐ R arm

PPD to be read: ____/____/____ Manufacturer: _____ Lot #: _____ Exp. Date: _____

RESULTS: Reading date: ____/____/____ MM of Induration: _____ mm Read by: _____

Annual Tuberculosis Signs & Symptoms Questionnaire (ONLY IF POSITIVE PPD HISTORY)

Do you have a positive PPD history? Please complete below **annually** in place of a **PPD (tuberculin skin test/TST).**

1. In what year did you first have a positive reaction to the TB skin test? _____
2. Have you ever received the BCG vaccine? . . . . ☐ Yes ☐ No If yes, when? _____
3. Date/location of most recent chest x-ray: _____
   Results: _____
4. Treatment for latent TB? . . . . . ☐ Yes ☐ No Duration/Dates: _____
5. Do you have any of the following:
   a. Persistent cough. . . . . ☐ Yes ☐ No If yes, when did it start? _____
   b. Sputum . . . . . ☐ Yes ☐ No If yes, when did it start? _____
   c. Unexplained weight loss. . . . . ☐ Yes ☐ No If yes, when did it start? _____
   d. Prolonged fevers. . . . . ☐ Yes ☐ No If yes, when did it start? _____
   e. Night sweats . . . . . ☐ Yes ☐ No If yes, when did it start? _____
   f. Undue fatigue . . . . . ☐ Yes ☐ No If yes, when did it start? _____
6. Tobacco history. . . . . ☐ Yes ☐ No _____ packs per day _____ # of years
7. Current smoker . . . . . ☐ Yes ☐ No _____ packs per day
   a. Cigars/Pipes . . . . . ☐ Yes ☐ No How much: _____
8. Current steroid use . . . . . ☐ Yes ☐ No Dose: _____
9. Current lung disorder . . . . . ☐ Yes ☐ No

Patient Name (Print) Signature Date of completion

FOR PROVIDER USE ONLY

UHS Nursing Review: _____ **Date:** ____/____/____

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