Attachment 8

OHIO VETERANS HOMES

TUBERCULOSIS SCREENING/SYMPTOM SURVEY

THIS SECTION TO BE COMPLETED BY APPLICANT.

Print Name: _____ Date: _____

LAST ____ *FIRST*

Check box if you have experienced any of the following symptoms recently for no known reason.
Examples of known reasons might be night sweats as a result of hormonal changes, chronic cough as a result of smoking, indigestion related to ulcer disease, etc.

YES	*NO*	
☐	☐	Coughing Up Blood
☐	☐	Night Sweats
☐	☐	Unexplained Persistent Indigestion
☐	☐	Decreased Appetite
☐	☐	Unexplained Chronic Cough (for more than 2 weeks)
☐	☐	Unexplained Chronic Fatigue, Listlessness (more than 2 weeks duration)
☐	☐	Unexplained Weight Loss (8 pounds or more or 10% of normal body weight)
☐	☐	Low grade fever – late afternoon or evening – lasting more than 1 week

_____
Applicant's signature

THIS SECTION TO BE FILLED OUT BY TESTING SITE.

PPD	Mfg	Lot #/exp date	DATE GIVEN	SITE	DATE READ 48 – 72 hrs. after applied	RESULTS	ADMINISTERED BY
1st Step							
2nd Step							

NOTE: If previously tested, must provide documentation– date given, date read & results in mm.

THIS SECTION TO BE COMPLETED BY PHYSICAN *IF* APPLICANT IS A TST CONVERTER OR KNOWN POSITIVE REACTOR.

Date converted:	
DATE OF CHEST X-RAY	**RESULTS OF CHEST X-RAY** – include a copy of report
Physician' statement and evaluation of applicants TB status:	
☐ Applicant is free from active pulmonary tuberculosis and is cleared medically to work.	
Treatment:	
Physician's Signature:	**Date:**

NOTE: CDC recommendation is that persons with a documented conversion and no evidence of TB on chest x-ray receive preventative therapy unless medically contraindicated