ARIZONA'S CHILDREN ASSOCIATION

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TUBERCULIN (MANTOUX) SKIN TEST OR X-RAY OR PHYSICIAN ASSESSMENT

Results must be ***Submitted to Recruitment PRIOR to 1st Day of Hire*** to be registered for New Employee Orientation (NEO)

- Take this form with you to your doctor's visit - **Remember** to schedule early enough to allow 3 days from test date for results to be available
- TB required annually thereafter

PATIENTS NAME: _____

ADMINISTRATED BY:

NAME: _____

TITLE: _____

HEALTH CARE FACILITY: _____

FACILITY PHONE NUMBER: _____

ADMINISTRATED BY (Signature): _____

DATE: _____ TIME: _____

RESULTS VERIFIED BY: (Mantoux Skin Test must be read within 72 hours from date administered)

NAME: _____

TITLE/FACILITY: _____

VERIFIED BY (Signature): _____

DATE: _____ TIME: _____

COMPLETE APPLICABLE SECTION

MANTOUX SKIN TEST RESULTS (Circle One): NEGATIVE POSITIVE

X-RAY RESULTS (Circle One): NEGATIVE POSITIVE

Physician Assessment: *Please complete page 2 if skin test has been positive and X-Ray was completed within last 2 years

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PHYSICIAN ASSESSMENT

*Tuberculosis Screening Questionnaire for Those Who Require an **X-Ray***

If you have received a chest x-ray within the past 2 years to rule out the disease, please complete this screening questionnaire. This questionnaire will allow your physician to determine whether or not you are free from signs and symptoms of tuberculosis.

EMPLOYEE'S PRINTED NAME: _____

Please read and answer the following questions:

1. Have you been exposed to any patients during the course of your work in the last year who carried the diagnosis of active pulmonary tuberculosis? _____
2. Are you experiencing chronic, recurrent, intermittent fever? _____
3. Are you experience chronic, recurrent, intermittent chills? _____
4. Do you experience profuse sweating during the night (e.g. enough to require changing your night clothes)? _____
5. Do you have asthma, emphysema, or chronic bronchitis? _____
6. Do you experience wheezing? _____
7. Apart from colds, sore throats or episodic bronchitis, are you experiencing a cough which has lasted more than two weeks? _____
8. Do you cough up phlegm on more mornings? _____
9. Have you coughed up any bloody or blood-streaked sputum? _____
10. Have you had pneumonia or other serious lung disease in the last year? _____
11. If yes, please explain: _____
12. Has anyone close to you or in your family been diagnosed as having tuberculosis? _____
13. Do you smoke cigarettes? _____
    a. If yes, how many cigarettes per day? _____

EMPLOYEE'S SIGNATURE:_____DATE: _____

This employee is free and clear of signs and symptoms associated with tuberculosis.

PHYSICIAN'S NAME: _____

PHYSICIAN'S SIGNATURE:_____DATE: _____