Tuberculosis Screening Questionnaire

Complete This Form Only If You Have Had a Positive TB Screen

Print Name

Date

Proof of Positive TB Screen — Attach Required Documentation:
(unless documentation currently on file with Supplemental Health Care)
- Positive TB Screen Results (i.e. TB Skin Test, PPD), OR
- Positive IGRA Results (i.e. QuantiFERON, T-Spot), OR
- Chest X-Ray with reason for study indicating positive TB screen, OR
- Physician or Public Health Official document attesting to history of positive TB screen

Note: History of receiving the BCG Vaccine is not a contraindication to having an annual TB screen. You must be able to also provide proof of positive TB Screen

Date of Positive TB Screen: __________

Most Recent Chest X-Ray
Please attach copy of X-Ray results or Physician’s Report of X-Ray results

Date of most recent Chest X-Ray: __________

Please indicate if you are having, or have had, any of the following problems for three to four weeks or longer:

1. Chronic Cough (greater than 3 weeks) □ Yes □ No
2. Production of Sputum □ Yes □ No
3. Blood-Streaked Sputum □ Yes □ No
4. Unexplained Weight Loss □ Yes □ No
5. Fever □ Yes □ No
6. Fatigue / Tiredness □ Yes □ No
7. Night Sweats □ Yes □ No
8. Shortness of Breath □ Yes □ No

By signing below, I am attesting that I have had a history of a positive TB screen, supported with documentation, and have answered the above questions related to symptoms truthfully.

Talent Signature

SHC Representative Signature