North Central Wisconsin Healthcare Alliance

Tuberculosis Screening Form

Name:_____ Date:_____

Phone:_____ Email:_____

Your records indicate that you had a positive tuberculin (TB) test. You are required to complete this form to assess risk and symptoms of tuberculosis infection. Please be aware of these symptoms and notify your school immediately if they occur. Students who have reacted positively in the past are required to provide the results of one baseline chest X-ray and complete this screening annually.

Risk Assessment:	**Yes**	**No**
1. Have traveled outside the U.S. and/Canada in the last 12 months? If yes, when?_____ Where?_____	☐	☐
2. Have you had close contact (i.e. those sharing the same household or other enclosed environments) with persons known or suspected to have TB? If yes, when?_____ Where?_____	☐	☐
3. Have you worked in any of the following high-risk congregated settings (i.e. correctional institutions, nursing homes, other long-term residential facilities, and shelters for the homeless)? If yes, when?_____ Where?_____	☐	☐
4. If applicable, are you a healthcare worker who has worked in high-risk areas (i.e. respiratory, therapy, pulmonary clinic, etc)? If yes, when?_____ Where?_____	☐	☐
5. Are you foreign-born or have you recently arrived (within 5 years) from countries with a high TB incidence or prevalence? If yes, when?_____ Where?_____	☐	☐
Symptoms:		
Do you currently have:		
1. Episodes of fatigue?	☐	☐
2. Episodes of fever?	☐	☐
3. Chills?	☐	☐
4. Unexplained weight loss?	☐	☐
5. Cough (greater than 3 weeks) unrelated to another diagnosis?	☐	☐
6. Chest pain?	☐	☐
7. Cough that has produced blood-streaked phlegm?	☐	☐
8. Hoarseness of your voice while speaking?	☐	☐
9. Night sweats unrelated to menopause?	☐	☐
10. Have you sought medical evaluation of these symptoms?	☐	☐

If yes, please explain:

To sign, please click on SIGN (right corner) and PLACE SIGNATURE. This will prompt you to drag a box on the signature line.

A new window will pop up asking you how you want to sign this document. If you don't have an EXISTING DIGITAL ID, please CREATE ONE NOW.

Student Signature_____ Date_____

FOR OFFICE USE ONLY

Reviewd by (Academic Institution signature)_____ Date_____

Positive Results: Forwarded to Employee Health (signature)_____ Date_____

Approved/Denied by Employee Health:_____ Date_____