## TUBERCULOSIS SCREENING FORM 2013

to be screen	ned for tubero		to comply with Sepployment or doing v	ction 25103, Titl volunteer work, a	e 10, Guam C and annually t	ne by Yode Annotated, which requires you hereafter. Failure to comply can and						
Please note	the following	g:										
-	- The items on this form require that they be completed within certain time Period to be valid. Different items have different time periods.											
-	Applicar	nts for employment must fin	st submit of this for	rm to the Person	nel Services D	Division before beginning work.						
Name of Er	nployee/Volu	unteer:		Γ	D. O. B							
Social Secu	rity #:		We	Work Location/Dept.:								
			DIRECT	TIONS								
Directions:	Continue to another item. Items shown in small print must be completed by a Physician, Physician's Assistant (PA), Nurse Practitioner (NP), or Nurse; refer to each item for specifics.											
		a positive TB test reactor <u>build</u> under or have received com			3, start with It	em 6.						
2.	2. Obtain a PPD skin test and have the following information complete. Then do Item 3. (The results must be less than a year old on the date at the top to be valid. You may attach other medical documentation to this form with shows the date of administration and reading of a PPD instead of having this items completed. However, you are still responsible for having all other items which apply to your situation properly completed on this form.).											
Date admi	nistered:	Date read	1:	Results:		mm						
Name of Ph	nysician, PA/	Nurse (print)	Date	_	Signature o	of Physician, PA/ Nurse						
3.		alt from Item 2 is 0-9mm or sult from Item 2 is 10mm or	-	_	ems.							
4.	Obtain a chest X-ray and: a) Have the following completed by only a Physician, PA, or NP; and b) Attach a radiology report concerning the X-ray from a licensed radiologist. Then do Item 5. (If this is done in compliance with Item 3: the X-ray must have been conducted no sooner than in six months prior to the PPD required by item 2 to be considered valid. If this is done in compliance with Item 6: the X-ray must have been conducted no sooner than six months prior to the date shown at the top of the other side to be considered valid). If you are pregnant, do Item 7 if you are less than 20 weeks pregnant (in this case Item 7 may be completed only by a Physician); otherwise, do this item, then Item 5 (tell the clinic you need an abdominally shielded X-ray because of your pregnancy).											
	1.)	Are X-ray results sugge	estive of TB?	[ ] yes	]	] no						
	2.)	Date the X-ray was adm	ninistered:			_						
	3.)	Is the patent currently of	on INH prevention t	herapy? [ ] ye	es [	] no						

		If not, pleas	e sta	te reason:									
	[ ] Patient refused INH preventive therapy offered												
	[ ] Patient over 35 years of age with no risk factor												
	[ ] Patient referred to DPH&SS for possible INH preventive therapy												
	[ ] Patient referred to DPH&SS for possible active TB												
		O	ther:					<del></del>					
Name of Physician, PA/NP/Nurse (print)						D	OATE		Signature of Physician/PA/NP/Nurse				
	5.			swer to Item 4. swer to Item 4.				lowing items.					
	6.	<ul> <li>a.) If the last time you had a chest X-ray was during or before 2007: do Item 4.</li> <li>b.) If you had a chest X-ray after 2007 and had submitted its radiology report with Item 4 properly completed to the University of Guam for a previous TB screening: do Item 7. Otherwise, do Item 4.</li> </ul>											
	7.) Have the following item completed by only a Physician, Physician's Assistant (PA), or Nurse Practitioner (NP). Then do Item 8. (This item must have been completed no sooner than one year prior to the date shown at the top of the other side to be valid.)												
		Do	es the	e person name or	n page 1 have	any	of the follo	wing?					
A.)	Chron	ic cough: (Two (	2) we	eeks duration or l	longer)	]	] YES [	] NO					
B.)	Chroni	Chronic cough with sputum				[	] YES [	] NO If yes, co	olor of sputum				
C.)	Cough	Coughing Blood					] YES [	] NO					
D.)	Persist	Persistent night sweats					] YES [	] NO					
E.)	Involuntary Weight Loss					[	] YES [	] NO					
F.)	Unexplained fevers					[	] YES [	] NO					
Name of Physician/PA/NP (print) DA			DATE		-	Signature	of Physician/PA/NP						
	8.	a.) If all of Items.	the	symptoms A-F	in Item 7 w	ere	answered '	'no", disregard	the remaining				
	<ul><li>b.) If any of the symptoms A-F were answered "yes" in Item 7: do Item 4. (However, in this case the X-ray requested by Item 4 will be considered valid only if it has been conducted no more than one month prior to, or anytime when Item 7 has been signed).</li></ul>												
9. Have the TB Control Section of the Department of Public Health & Social Services in Mangilao comfollowing: clearances from anywhere else will not be accepted (Call 735-7145/7157 for an appointment so, ask what documents you should bring to get cleared). You may return to work or resume your job on the date indicated on the left below.													
May start/return to work on:			DI	PH&	SS stamp:								
DPH8	&SS Staff	Signature:				_ D	ate:						