B's Homecare Inc.

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Baseline TB Screening Tool for Health Care Workers (HCWs)

_____ Last name, first name, middle initial

____/____/_____ Date form completed

____/____/_____ Date of birth

(_____)_____ Work phone number

Baseline TB screening includes three components:

(1) Assessing for current symptoms of active TB disease
and
(2) Assessing HCW's history
and
(3) Testing for the presence of infection with *Mycobacterium tuberculosis* by administering either a single TB blood test *or* a two-step TST.

Symptoms of active TB disease (circle all that are present)

Coughing (>3 weeks)	Chest pain	Fatigue
Night sweats	Coughing up blood	
Weight loss/poor appetite	Fever/chills	

Note: If TB symptoms are present, promptly refer HCW for a chest X-ray and medical evaluation before starting work. Do not wait for the TST or TB blood test result.

HCW's history (circle response)

Have you ever had a positive reaction to a TB skin test or TB blood test? Yes No
If yes: Date_____ Number of millimeters of induration _____

Have you had a TB skin test in the past 12 months? Yes No
If yes: Date_____ Number of millimeters of induration _____ Result _____

			Comments
Have you ever had the BCG vaccine?	Yes	No	
Have you ever been treated for latent TB infection?	Yes	No	
Have you ever been treated for active TB disease?	Yes	No	
Have you ever had an adverse reaction to a TB skin test?	Yes	No	
Have you received a live-virus vaccine within the past 6 weeks?	Yes	No	

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TB Blood Test

Name of TB blood test (circle)	QuantiFERON TB-Gold QuantiFERON-TB-Gold InTube T-SPOT
Date of blood draw	
Results	
Interpretation of reading (circle)	Positive* Negative Indeterminate
Laboratory	

*Refer HCW for a chest x-ray and medical examination to rule out active infectious TB disease

Tuberculin skin testing (TST)

	TST – First Step	TST – Second Step
Administration		
Name of person administering test		
Date and time administered		
Location (circle)	L forearm R forearm Other:_____	L forearm R forearm Other:_____
Tuberculin manufacturer		
Tuberculin expiration date and lot #		
Signature of person who administered test		
Results (read between 48-72 hours)		
Date and time read:		
Number of mm of induration: (**across** forearm)	____mm	____mm
Interpretation of reading* (circle)	Positive** Negative***	Positive** Negative
Reader's signature		

*Consult grid at www.health.state.mn.us/divs/idepc/diseases/tb/candidates.pdf
** Refer HCW for a chest x-ray to rule out active TB disease
*** If results are negative, perform the second step in one to three weeks

Adapted by the Minnesota Department of Health TB Prevention and Control Program from materials produced by the Global TB Institute and the Francis J. Curry National TB Center