UCLA Health
Occupational Health
10833 Le Conte Ave. #17-240
Los Angeles, CA 900951-1725
Phone: (310) 825-6771
Email completed form to: OccupationalHealth@mednet.ucla.edu

Tuberculosis Screening

Name: _____ Department: _____

DOB: _____ Staff ID: _____ Phone Number: _____

UCLA Email Address: _____

Staff's Supervisor: _____

Supervisor's UCLA Email: _____

Reason for screening (check all that apply): ☐ New Staff ☐ Exposures ☐ Other: _____ ☐ Staff Annual ☐ Volunteer

EMPLOYEE HEALTH ONLY:

TB Exposure Date: _____ Baseline: _____ 8-10wk Post Exposure: _____

I have a history of a positive TB skin test, T Spot, or Quantiferon Blood Test (Check one): ☐No ☐Yes

If yes, include the date: _____

I have taken INH or other medication in the past for TB infection or disease. ☐No ☐Yes

If yes, include the date: _____ *Number of months:* _____ *Medication:* _____

I was born, have resided, or traveled in a foreign country for at least 1 month. ☐No ☐Yes

If yes, list the countries: _____

All staff must answer the following questions EVERY year:

(If you answer "yes" to any question below, please call Occupational Health for an appointment at 310-825-6771.)

1. Do you have:

Recent contact of a person with active Tuberculosis	☐Yes	☐No
Any condition that decreases your immune system	☐Yes	☐No
An organ transplant	☐Yes	☐No

2. Since your last TB Test, have you had any of the following <u>active</u> **TB symptoms** for **more than 3 weeks**?

Coughing up blood	☐Yes	☐No	Persistent fever	☐Yes	☐No
Persistent Coughing	☐Yes	☐No	Hoarseness	☐Yes	☐No
Excessive fatigue	☐Yes	☐No	Unexplained weight loss	☐Yes	☐No
Excessive sweating at night	☐Yes	☐No			

Staff Member's Signature: _____ Date: _____ Time: _____