UCLA Health

Occupational Health Facility
10833 Le Conte Ave, CHS 67-120
Los Angeles, CA 90095-1725 Phone (310) 825–6771
Email completed form to: Occupationalhealth@mednet.ucla.edu

Employee Health only
TB Screen Result:
☐ Cleared
☐ Not Cleared
_____
Reviewer Signature
_____
Reviewer Name
_____
Date

Tuberculosis Screen

Staff Member to complete the top half of page and sign

Name: _____ **Department:** _____

DOB: _____ **Staff ID:** _____ **Phone number:** _____

Email Address: _____

Staff's Supervisor: _____ **Email:** _____

Reason for screening (check all that apply)

☐ New Staff ☐ Physician Re-Credentialing ☐ SM Care Extender
☐ Staff Annual ☐ Volunteer ☐ Other: _____

Employee Health Only _____
TB Exposure Date _____ Baseline _____ 8-10 wk Post Exposure_____

I have a history of a positive TB Skin Test, T-SPOT or Quantiferon Blood Test (Check one): ☐ No ☐ Yes – Date _____
I have taken INH or other medication in the past for TB infection or disease: ☐ YES – Dates: _____
Number of months: _____ Medication: _____ ☐ NO
I was born, have resided or travelled in a foreign country for at least 1 month
☐ No ☐ Yes (list countries) _____

All staff must answer the following questions EVERY year: (if you answer "yes" to any question below please return this form directly to OHF or SM Employee Health to be evaluated for safety at work)

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 active **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:** _____

Employee Health Only

TB Skin Test (annual) Date: ____/____/____ Right ☐ Left ☐ Placed By: _____

5TU dose PPD (0.1cc) Manufacturer: Aventis Sanofi Pasteur Lot Number: _____ Expiration Date: _____

Skin Test Reading Date: ____/____/____ Result: ☐ Negative _____ mm induration ☐ Positive _____ mm induration

Read by: _____

Quantiferon Blood Draw Date Requested: _____/_____/_____ Result: ☐ Negative ☐ Positive ☐ Indeterminate

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Chest X-Ray: Only for (1) new hires with a positive TST, (2) initial evaluation of new TST converters, (3) established positive TST staff that have TB symptoms, and (4) to initially evaluate any healthcare provider with ≥ 5mm induration. All staff with active TB symptoms shall be restricted from work until official radiological interpretation.

Date Requested:____/____/____ Date Reviewed:____/____/____ Result: _____

Action: _____ Reviewed by: _____ Date:___/___/___