Department of Veterans Affairs Medical Center

Philadelphia, Pennsylvania 19104

**VOLUNTEER TB SCREENING**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Service: Center for Development & Civic Engagement

SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: VOLUNTEER

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Extension:5868

**Section A – Current Symptoms**

Please check the appropriate line if you are currently having any of the following symptoms:

\_\_\_\_Weight Loss \_\_\_\_\_Chest Pain \_\_\_\_\_Night Sweats \_\_\_\_Malaise \_\_\_\_\_Shortness of Breath \_\_\_\_\_Persistent Cough

\_\_\_\_Bloody Sputum

\_\_\_\_\_No, I do not have any of these symptoms

**Section B – TB history**

A) Have you ever had a PPD? No \_\_\_\_Yes\_\_\_ Last PPD, if known\_\_\_\_\_\_\_Result:\_\_\_\_\_

B) Have you had BCG? No \_\_\_\_Yes\_\_\_\_

C) Have you had a **Positive PPD? No \_\_\_\_Yes \_\_\_\_ If yes, answer Section C**

D) Have you had a TB blood test (QuantiFERON or T-Spot)? No \_\_\_\_**Yes**\_\_\_\_

E) Have you ever been exposed to a case of Active TB? No \_\_\_Yes\_\_\_\_Don’t know\_\_\_

F) Are you on any medications or do you have any illnesses that that might suppress your immune response? (examples: Chemotherapy, treatment for autoimmune conditions, organ transplants or steroids, AIDS, Multiple Myeloma, Leukemia, etc.) No \_\_\_\_\_ Yes \_\_\_\_

If yes, what medicine/illness? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

G) Are you currently (or in the last 6 months) undergoing Radiation therapy treatments?

No \_\_\_\_\_ Yes\_\_\_\_\_

**Section C - to be answered if PPD positive or blood test positive**

A) Have you ever been treated for TB? No\_\_\_\_\_\_ Yes\_\_\_\_\_\_

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ What medication(s) did you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

B) When was your last Chest X-ray? Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Don’t Remember:\_\_\_\_\_\_\_

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**Volunteer Signature**

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**ORDERED:**

**QFT-GOLD\_\_\_\_\_\_\_\_\_\_ / T-SPOT\_\_\_\_\_\_\_\_\_\_\_**

**Section D: *for Occupational Health Only***:

THE INFORMATION ABOVE HAS BEEN REVIEWED WITH THE EMPLOYEE – EMPLOYEE VERBALIZED UNDERSTANDING.

\_\_\_\_\_.1cc PPD given in \_R or L\_\_Forearm Manufacturer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lot #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PROVIDER’S SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Result of PPD:\_\_\_\_\_\_\_\_\_\_\_mm Induration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PROVIDER’S SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_