San Francisco VA Health Care System – Employee Health Clinic
4150 Clement Street, Building 203, GB 17, San Francisco, CA 94121
Tuberculosis Screening and Testing Form

Last Name _____ **First Name** _____

DOB(mm/dd/yyyy) _____/_____/_____ **SS# (Last four)** _____ _____ _____ _____

Work Ext __2__ _____ _____ _____ _____ **Home/Cell #** (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Check only one: ☐**VA Paid Employee** ☐**WOC (Without Compensation)** ☐**NCIRE**
☐**UCSF Resident/Fellow** ☐**Volunteer** ☐**Other**_____

Job Title: _____ Service/Department/Unit: _____

Purpose of Test: ☐ **Preemployment/Clearance** ☐ **Annual** ☐ **Post Exposure** ☐ **Other**: _____

Symptom Review
Please check any symptoms you have had for more than three weeks within the last 12 months:

☐ Persistent cough ☐ Excessive fatigue ☐ Excessive sweating at night

☐ Coughing up blood ☐ Excessive weight loss ☐ Persistent fever ☐ **None**

Contact and Health History

1. Have you ever lived one month or more *outside* of the USA, northern Europe, Australia, or New Zealand?	☐ Yes	☐ No
1a. *If yes, where:* _____		
2. Have you had contact with an active case of TB at work or at home at any time?	☐ Yes	☐ No
2a. *If yes, when is the most recent date*? _____/_____(mm/yyyy)		
3. Have you been told by a healthcare provider that you have a positive test for TB (blood or skin test)?	☐ Yes	☐ No
3a. *If yes, have you ever been treated with medication for 4 months or longer for a positive TB test (skin or blood) or for active TB?*	☐ Yes	☐ No
3b. *If yes to question 3a, please detail:* _____		
4. Have you ever received a BCG vaccine? (TB vaccine given outside of the U.S.)	☐ Yes	☐ No
5. Have you ever been told by a health care provider that your immune system is compromised, not working, or that you are unable to fight infections?	☐ Yes	☐ No
5a. *If yes, please detail:* _____		
6. Are you taking or plan to take a medication that suppresses the immune system?	☐ Yes	☐ No
6a. *If yes, please detail:* _____		

I attest the above is true.

Employee Signature _____ Date_____/_____/_____(mm/dd/yyyy)

Protocol: □ Symptom Screening only □ 1 Step □ 2 Step □ Other (please detail)_____

Date Placed	Solution/Lot #/Exp. Date		Placed by: Name/Title/Date	Read: Name/Title/Date	mm induration	
TST #1		**RFA/LFA**				☐ OHIC
TST #2		**RFA/LFA**				☐ OHIC

_____ _____ _____
EOH Reviewer's Printed Name **EOH Reviewer's Signature and Title** **Date**

FOR DOCUMENT SUBMISSION IF NEEDED Email: VHASFCOccupationalHealthFax@va.gov Secure Fax: (415)750-2156

Updated 01/15/2020