Volunteer Tuberculosis *Screening and Surveillance Questionnaire*

Volunteer Name:_____ Date of Birth: _____

Site_____

Please answer the following questions and forward completed form to Colleague Health Services. *Thank you!*		
Have you ever had a positive TB skin test, TB Quantiferon Gold, or T-Spot? If yes, list which test(s) were positive and date(s):	Yes	No
Have you ever been told you have TB or been treated for latent TB infection? If yes, list details:	Yes	No
Have you ever been exposed to someone with known TB disease or lived with or had close contact with someone who has TB disease? If yes, list details:	Yes	No
Were you born in a high TB-prevalence country (any country other than the United States, Canada, Australia, New Zealand or a country in Western or Northern Europe)? If yes, list where you were you born:	Yes	No
Have you traveled to a high TB-prevalence country for **more than one month**? Note: High TB-prevalence country includes any country other than the United States, Canada, Australia, New Zealand or a country in Western or Northern Europe). If yes, list when and where you traveled:	Yes	No
Are you a current or former resident of, or worked in a high-risk setting in states with higher TB-prevalence (Alaska, California, Florida, Hawaii, New Jersey, New York and Washington DC)? If yes, list details:	Yes	No
Have you ever received BCG vaccination? If yes, list what year you received the vaccination?	Yes	No
In the past year, have you had a persistent cough for **more than 3 weeks** AND one or more of the following symptoms?		
Productive, prolonged cough (for more than 3 weeks)	Yes	No
Night sweats	Yes	No
Loss of appetite	Yes	No
Unexplained fever	Yes	No
Coughing up blood	Yes	No
Unexplained fatigue	Yes	No
Unexplained weight loss	Yes	No
Are you currently taking steroids/immunosuppressive therapy? If yes, provide details:	Yes	No
Have you received any live virus vaccines within the last month or plan to receive any in the next month? **NOTE:** Live virus vaccines may interfere with IGRAs (TB Quantiferon/TSpot); Perform on the same day or allow 4 weeks between.	Yes	No

I affirm that I have answered these questions to the best of my knowledge and that the answers are accurate and complete.

Volunteer Signature: _____ Date: _____

This section for Colleague Health Nurse/LHCP Use Only

Comments: _____

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Note: If immunosuppressed, volunteer will be required to complete TB Screening and Surveillance Questionnaire on an annual basis.

Occupational Health Nurse Signature: _____ Date: _____

HSHS St. Vincent St. Mary's St. Nicholas St. Clare | Volunteer Services