PROVIDENCE ANCHORAGE LONG TERM CARE SERVICES
TUBERCULOSIS SCREENING

Patient/Resident Name: ______________________________

All individuals seeking admissions to Providence Extended Care or Providence Transitional Care Center must be free of active signs and symptoms of TUBERCULOSIS.

Does Patient/Resident Have:

- ❑ History of Tuberculosis per record? ___ yes / ___ no
- ❑ History of Positive TST per record? ___ yes / ___ no

If Yes, ASK:

- ❑ Have you ever been told you have TB? ___ yes *(if yes ________date?)* / ___ no
- ❑ Have you ever had a positive skin test? ___ yes *(if yes ________date?)* / ___ no
- ❑ Have you ever had positive blood testing for (Quantiferon)? ___ yes *(if yes ________date?)* / ___ no
- ❑ Have you been treated for TB? ___ yes *(if yes ________date?)* / ___ no
- ❑ Have you ever received medications because of a positive skin test? ___ yes *(if yes ________date?)* / ___ no
- ❑ Have you received BCG vaccine and when? ___ yes *(if yes ________date?)* / ___ no
- ❑ What is your country of origin? ____________________________
- ❑ Have you lived or traveled in any country within the last 10 years? __________________________

All Applicants must:

1) Have a CXR negative for findings of Tuberculosis within 60 days prior to admission.
2) Have a negative screening for active signs and symptoms of TB performed by either a registered nurse or a physician.

Chest X-Ray done: ____

Results: ____

Screening Questionnaire for signs and symptoms of active Tuberculosis:

Has patient/resident had any of the following signs and symptoms during the past (1) one year?

Please Check any of the following	**If Yes, Give Dates:** YES	NO
1) Cough lasting greater than 2 weeks	_______	_______
2) Blood tinged sputum	_______	_______
3) Night sweats	_______	_______
4) Unexplained weight loss	_______	_______
5) Loss of appetite	_______	_______
6) Unexplained fever	_______	_______

If yes to any question, please describe symptoms further. When did it start? Have you sought treatment? If yes, what treatment was done?

____

RN, ANP or Physician Signature Completing form Date

____

RN, ANP or Physician Please Print Name