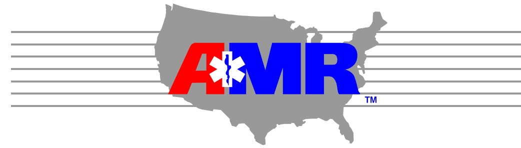


AMERICAN MEDICAL RESPONSE

Tuberculosis Screening Program

Name (PRINT) ______________________ Address ____________________

EE#: ______________________ ____________________

DOB: ____/____/____ Phone #:____________________

Check One: ___**Routine** (Every 12 mos.) ___**Initial TB Test** ___**Post Exposure**

****

1. Last TB test: Date: ___________ Result: ___________

****

(Circle)

2. Have you ever had a positive TB test or been diagnosed with TB? **Yes / No**

If No, skip to #3

A. When did you convert or were diagnosed? Date: ____________

B. Were you prescribed medication? **Yes / No**

C. Did you complete the entire course of medical treatment? **Yes / No**

D. **Last chest x-ray:** Date: __________ Result: ___________

E. Name and location of treating physician: ______________________________

****

3. Have you experienced any of these six (6) symptoms within the past year?

A. Persistent Cough **Yes / No**

B. Coughing Up Blood **Yes / No**

C. Night Sweats **Yes / No**

D. Recurring Fever **Yes / No**

E. Unexplained Weight Loss **Yes / No**

F. Excessive Fatigue / Tiredness **Yes / No**

****

4. Persons with the following conditions **require different test parameters** for TB skin test interpretation. Do any of these conditions apply to you? **Yes / No**

- HIV infection
- Risk factors for HIV with unknown HIV status
- Immunocompromised due to other medical conditions, such as diabetes requiring insulin, long-term use of corticosteroids, or other immune suppressing medications
- Prolonged contact (household, not healthcare) with an infectious TB case

****

5. Have you had any immunizations/vaccinations in the past six weeks? **Yes / No**

List the vaccinations you have had and when. (i.e., flu, varicella, measles, mumps, rubella, polio, etc.): ____

****

6. Did you ever receive BCG, a TB vaccine given in other countries? **Yes / No**

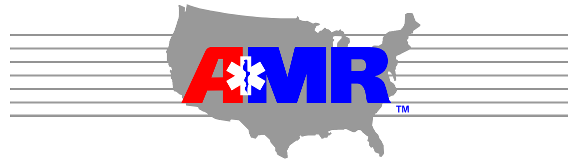
****

7. List any known allergies to foods, medications, or latex: ____________________________

Employee Signature: ___________________________________ **Date:** ___________

Immunization RN (Print/Sign Name)____

This Portion is to be completed by an AMR licensed healthcare professional or designee.



AMERICAN MEDICAL RESPONSE

Employee Name: ________________________________

Tuberculin PPD (Mantoux) Test

Test #1

Date Given: ________ Time: _____AM/PM Site: R/L forearm Lot#: ________ Exp. Date: _____
(Circle) (Circle)

Window for having test read:

Between _____(Time) on ___________(Date) until________(Time) on___________(Date)*

Date Read: ___________ Time: _____ AM/PM Induration: ___mm

By: (Print) ____________________ Signature: ___________________________

Interpretation By: (Print) ________________(RN/MD) Signature: ______________________________

***Must be read within 48-72 hours of test placement by AMR-approved personnel only**

****

Test #2 (if needed)

Date Given: ________ Time: _____AM/PM Site: R/L forearm Lot#: ________ Exp. Date: _____
(Circle) (Circle)

Window for having test read:

Between _____(Time) on ___________(Date) until________(Time) on___________(Date)*

Date Read: ___________ Time: _____ AM/PM Induration: ___mm

By: (Print) ____________________ Signature: ___________________________

Interpretation By: (Print) ________________(RN/MD) Signature: ______________________________

***Must be read within 48-72 hours of test placement by AMR-approved personnel only**

****

History and Symptoms Review ___Negative ___Positive

Referral made? ___No ___Yes To: ___________________ Date: ____________
(Occupational Clinic or PMD)

Exemption from PPD Skin Test (if applicable)

Attach documentation of:

- ☐ Prior positive PPD reaction in mm, or
- ☐ Medical history of TB, or
- ☐ TB drug administration record (i.e., INH, RIF, PZA, EMB, etc.)

Reviewer's Name: ____________________________
(Print)

Signature: _________________________________ Date: ____________

Disposition: Employee's Confidential Medical Record File