



NL Health Services

Occupational Health Tuberculosis (TB) Screening Form

FOR OFFICE USE ONLY

Reason for completing: (Please check one)

Contact Tracing

New Hire/Rehire (if applicable)

New Hire/Rehire with prior positive TST

Name: _____

Employee #: _____

Date of Birth: _____ DD/MONTH/YYYY _____

HCN: _____

Please check Yes/No if you, or the person named above, have had any of the following:

	Yes	No
Tuberculosis skin test. If yes, most recent date: _____ DD/MM/YYY _____		
Positive Tuberculosis skin test		
Vaccine for Tuberculosis (Bacillus Calmette-Guérin (BCG) Vaccine)		
History of Active Tuberculosis Disease. If yes, when? ___ DD/MM/YYYY ___		
Treatment for Tuberculosis Infection/Latent TB. If yes, when? ___ DD/MM/YYYY ___		
Travelled to/ Born in / Lived in country with high numbers of Tuberculosis disease? (eg. India, China, Indonesia, Philippines, Pakistan, Nigeria, Bangladesh, & South Africa (for all-inclusive list, go to https://cdn.who.int/media/docs/default-source/hq-tuberculosis/who_globalhbcliststb_2021-2025_backgrounddocument.pdf?sfvrsn=f6b854c2_9)		
<ul style="list-style-type: none"> If "yes", include details such as length of travel time, location/country, and date last traveled: 		
Contact with a person with active Tuberculosis disease within the past 2 years		
<ul style="list-style-type: none"> If yes, was any testing done or review of symptoms? Please describe any follow up that was done here: 		

Have you, or the person named above, experienced any of the following symptoms*:

	Yes	No
Bad/persistent (ongoing) cough for more than 2 weeks		
Chest Pain		
Coughing up blood and/or thick sputum		
Fever and/or chills		
Lack of appetite		
Night sweats (unrelated to menopause)		
Unplanned weight loss		
Weakness/Tiredness		

Comments:

Employee/Student Print Name

Employee/Student Signature

Date: _____ (dd/mmm/yyyy)

OHN / Health Practitioner Print Name

OHN / Health Practitioner Signature

Date: _____ (dd/mmm/yyyy)

*If any risk factors are present, the Occupational Health Nurse (OHN) must discuss with the Occupational Health Physician (OHP). In absence of the OHP, please contact CDC Intake for further direction.