The Reutlinger Community

VOLUNTEER TUBERCULOSIS ASSESSMENT

Name: _____ DOB: _____

SSN: _____ Date of Hire: _____ Department: _____

Please check appropriate box.

1. In the past year, have you had any of the following symptoms?

	Yes	No
Coughing up blood……	☐	☐
Hoarseness lasting 3 weeks or more ……	☐	☐
Persistent cough lasting more than 3 weeks ……	☐	☐
Unexplained fatigue …….	☐	☐
Unexplained persistent fever lasting more than 3 weeks …….	☐	☐
Unexplained weight loss ……..	☐	☐
Loss of appetite …….	☐	☐
Chest pain ……..	☐	☐
Shortness of breath ……	☐	☐
Swollen glands ……...	☐	☐

If you answered yes to any item in question #1, please answer the following questions.

1. In the past year have you been told by a health provide that your immune system is not working or you can't fight infections?
2. Have you worked in a location where patients with active TB receive care and services?
3. Have you lived with or had close contact with a person who has TB?
4. Have you had an abnormal chest x-ray?
5. Have you worked, volunteered, or lived in any institution such as another medical facility, jail, group home, or homeless shelter?
6. Have you traveled outside the United States? If so where?

The answers to these questions are true to the best of my knowledge.

Print Name: _____

Signature: _____

Reviewed by: _____ Date: _____

Referral: Yes ☐ No ☐

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