

TUBERCULOSIS SCREENING FORM 2010

Please have this form completed properly, then submit it to the worksite whose payroll Turnaround Document lists your name by _____. This is necessary to comply with Section 25103, Title 10, Guam Code condition of employment or doing volunteer work, and annually thereafter. Failure to do so by the date give above can be grounds for placing you in leave without pay until the required documentation is submitted.

Please not the following:

- The items on this form require that they be completed within certain time Period to be valid. Different items have different time periods.
- Applicants for employment must first submit of this form to the Personnel Services Division, then, upon hiring, also provide a copy to the above mentioned worksite.

Name of Employee/Volunteer: _____ D. O. B. _____

Social Security #: _____ Work Location/Dept.: _____

Directions: *Completely read the following items and do what is indicated by them; many require you to Continue to another item. Items shown in small print must be completely by a Physician, Physician's Assistant (PA), Nurse Practitioner (NP), or Nurse; refer to each item for specifics.*

1. If you are not a positive TB test reactor, start wit Item 2.
If you are a positive TB test reactor, start with Item 6.
If you are under or have completed treatment for TB, do Item 9.
2. Obtain a PPD skin test from you r clinic and have the following information complete. Then do Item 3.
(The results must be less than a year old on the date at the top to be valid. You may attach other medical documentation to this form with shows the date of administration and reading of a PPD instead of having this items completed. However, you are still responsible for having all other items which apply to your situation properly completed on this form.).

Date administered: _____ Date read: _____ Results: _____ mm

Name of Physician, PA/ Nurse (print)

Signature of Physician, PA/ Nurse

3. a) If a result from Item 2 is 0-9mm, disagreed the following items.
b) If the result from Item 2 is 10mm or greater: do Item 4

Date administered: _____ Date read: _____ Result: _____ mm

Name of Physician, PA/Nurse (print)

Name of Physician, PA/ Nurse

If the result of Item 3.b is less than 10mm, disagreed the following items and submit this to the Worksite indicated in the above notice.

If the result of Item 3.b is 10mm or greater, do Item 4.

c.) If the result of Item 2 is 10mm or greater , do Item 4.

4. Obtain a chest X-ray and: a) Have the following completed by only a Physician, PA, or NP; and b) Attach a radiology report concerning the X-ray from a licensed radiologist. Then do Item 5. (The X-ray must have been conducted no more that six (6) months prior to, or anytime after, the PPD required by Item 4 to be considered valid.) If you are pregnant, do Item 7 if you are less than 20 weeks pregnant (in this case Item 7 may be completed only by a Physician); other wise, do Item 4 (tell the clinic you need an abdominally shielded X-ray because of your pregnancy), then do Item 5

1.) Are X-ray results suggestive of TB? _____ yes _____ no

- 2.) Date the X-ray was administered: _____
- 3.) Is the patient currently on INH prevention therapy: _____ yes _____ no
- _____ Patient refused INH preventive therapy offered
- _____ Patient over 35 years of age with no risk factor
- _____ Patient referred to DPH&SS for possible INH preventive therapy
- _____ Patient referred to DPH&SS for possible active TB
- Other: _____

Name of Physician, PA/NP/Nurse (print)

Signature of Physician/PA/NP/Nurse

5. a.) If the answer to Item 4.1 is "no", disregard the following items.
b.) If the answer to Item 4.1 is "yes", do Item 9
6. a.) If you have provided UOG with the results of a chest X-ray during or since SY 1999 - 2000 TB Screening or anytime thereafter: do Item 7.
- b.) If you have not provided the University with the results of a chest X-ray during or since SY 1999-2000, do Item 4. If you are pregnant, follow the guidelines given in Item 4.
- c.) If you have had a negative chest X-ray whose results will be less than five years old on the date shown at the top of the other side: do Item 7 and submit the X-ray results along with this form.
7. Have the following item complete by only a Physician, Physician's Assistant (PA), or Nurse Practitioner (NP). Then do Item 8. (This item must have been completed no sooner than one year prior to the date shown at the top of the other side to be valid.)

Does the person name on page 1 have any of the following?

- A.) Chronic cough: (Two (2) weeks duration or longer) _____ YES _____ NO
- B.) Chronic cough with sputum _____ YES _____ NO If yes, color of Sputum _____
- C.) Coughing Blood _____ YES _____ NO
- D.) Persistent night sweats _____ YES _____ NO
- E.) Involuntary Weight Loss _____ YES _____ NO
- F.) Unexplained fevers _____ YES _____ NO

Please explain if this person is under medical treatment for any condition

Name of Physician/PA/NP (print)

Signature of Physician/PA/NP

8. a.) If all of the symptoms A-F in Item 7 were answered "no", disregard the remaining items.
b.) If any of the symptoms A-F were answered "yes" in Item 7, do Item 4. (However, in this case, the X-ray required by Item 4 will be considered valid only if it has been conducted no more than one (1) month prior to, or anytime after, when Item 7 has been signed.)
9. TB Control Section of the Department of Public Health & Social Services in Mangilao complete Following; clearances from anywhere else will not be accepted. (Call 735-7145/7157 for an appointment. When doing so, ask what documents you should bring to get cleared.) You may return to work or resume your job application process on the date indicated on the left below.

May start/return to work on: _____ DPH&SS stamp: _____

DPH&SS Staff Signature: _____ Date: _____

POSITIVE REACTOR STATUS REPORT
MUST BE COMPLETED AND SUBMITTED WITH TB
EVALUATION CLEARANCE FORM ONLY IF THE PPD SKIN TEST IS POSITIVE

NAME _____	DOB _____
ADDRESS _____	ETHNICITY _____
PHONE(Home/Work): _____ / _____	

1. PPD Test: Date Given: _____ Date Recd: _____ Results: _____ mms

2. Chest X-Ray: Date _____ Normal _____ Abnormal _____

** NOTE: Radiological Interpretation by Licensed Radiologist Must be attached.*

3. INH Preventive Therapy Offered: Yes _____ No _____

4. Patient is currently on INH Preventive Therapy at my clinic.

Yes _____ No _____ Date Preventive Therapy Started: _____

5. If not on INH Preventive Therapy, please state reason:

___ a. Patient refuses INH Preventive Therapy offered.

___ b. Patient is over 35 years of age with no risk factor.

___ c. Other (Specify) _____

6. Patient cleared for work/School: Yes _____ No _____

7. Patient referred to DPHSS Communicable Disease Control Clinic for possible INH Preventive Therapy.

Yes _____ No _____

8. Patient referred to DPHSS Communicable Disease Control Clinic for possible active TB.

Yes _____ No _____

9. Comments: _____

Physicians' Signature

Date

Name of Physician/Clinic (print)