PLATT COLLEGE

Tuberculosis Symptom Screening Questionnaire

PPDs are required annually at Platt College due to clinical requirements; however, if a student has a chest X-ray the student will fill out a questionnaire annually about their respiratory health and it must be completed by a Healthcare Provider (*Currently Licensed Physician or Mid-Level Provider*). The Clinical Placement Coordinator or Associate Dean will then determine from the questionnaire if the student needs a repeat screening.

The questions (Part A) should be answered by the person for whom the TB Skin Test is required. A Healthcare Provider (*Currently Licensed Physician or Mid-Level Provider*) must then evaluate the answers and sign and stamp the recommendation (Part B).

PART A

1.	Have you experienced any of the following symptoms in the past year?			
	a.)	A productive cough for more than 3 weeks?	Yes	No
	b.)	Hemoptysis (coughing up blood)?	Yes	No
	c.)	Unexplained weight loss?	Yes	No
	d.)	Fever, Chills, or night sweats for no known reason?	Yes	No
	e.)	Persistent shortness of breath?	Yes	No
	f.)	Unexplained fatigue?	Yes	No
	g.)	Chest Pain?	Yes	No
2.	Have you had contact with anyone with active tuberculosis disease in the past year?		Yes	No

3. Why are you required to have a TB Skin Test? _____

Please provide details to any question answered "Yes"

I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.

_____ _____ _____

Signature of person required to be tested | Printed Name | Date

PART B

Upon review of these tuberculosis symptom questionnaire and discussion of this with the person for whom the tuberculosis evaluation is required, I recommend as follows:

_____There is no indication this person has active tuberculosis at this time.

_____There is reason to be suspicious of tuberculosis and further evaluation including a TB Skin test, Interferon Gamma Release Assay or other medical evaluation should be completed prior to clinical.

_____

Signature of Healthcare Professional Name

_____

Agency/Practice Name

_____

Contact Phone

_____

Date