RWJBarnabas Health School of Nursing

TB ASSESSMENT QUESTIONNAIRE

Student's Name: _____ Course: _____

Only complete this form if you have had a past TB positive result with a negative chest x-ray. The presence of symptoms below will determine further action.

Your health record indicates that you are not a candidate for tuberculosis assessment with TB skin testing or TB specific blood test. The following questions will assist in determining if you need further evaluation for active tuberculin disease.

Do you have?

1. Weakened immune system caused by radiation, chemotherapy, HIV infection, chronic illness, steroid medication?
   [ ] No [ ] Yes- it is not required to divulge your diagnosis.

2. Persistent cough?
   [ ] No [ ] Yes- explain_____

3. Fever and/or night sweats?
   [ ] No [ ] Yes- explain_____

4. Unexplained weight loss?
   [ ] No [ ] Yes- explain_____

5. Feeling ill/tired/weak?
   [ ] No [ ] Yes-explain_____

6. Chest pain or coughing up blood?
   [ ] No [ ] Yes-explain_____

Student's Signature: _____ Date:_____

If you answered "**YES**" to any of the above questions, further follow-up is required.
Please notify the Associate Dean. [ ] Yes [ ] No _____

Make an appointment with HCP [ ] Yes [ ] No _____

Request chest X-ray from HCP [ ] Yes [ ] No _____

Provide medical clearance [ ] Yes [ ] No _____

Signature of Associate Dean: _____ Date:_____