Occupational Health Department
Tuberculosis (TB) Screening Questionnaire

Identification

Name: _____ Employee ID: _____

Department: _____ Job Title: _____

Supervisor: _____ Supervisor Email: _____

Date of Birth: _____ Approximate date of hire in current workplace (Month/Year): _____

STATUS: *(Please check all that apply)*

Staff

- ☐ University of Arizona Employee
- ☐ DCC, DCC type code: _____

To determine your DCC Code consult:
https://hr.arizona.edu/sites/default/files/DCC_Srvc_Matrix.pdf

Student

- ☐ University of Arizona Student Employee
- ☐ Student (Academic) - completing this work in fulfillment of degree program or academic credit.
- ☐ Student (Volunteer) completing this work in support of University operations, not associated with fulfillment of degree program or any academic credit.

Requirement Check with your PI/Supervisor for Billing Information Required Below

Provide the UArizona Billing Account Number(s) associated with the Clinical Research or Healthcare Workplace for charges related to the immunization(s), referral(s) & laboratory analysis(es) you will require for employment or authorized presence in the workplace. If a sponsored project account is provided the cost must be incurred within the period of performance. Split funding costs (by percentage if multiple accounts listed) to multiple accounts must be specified based on an allocation basis such as benefit to the project.

UArizona Billing Account:

_____

Patient Acknowledgement:

☐ I acknowledge that the Tuberculosis (Tb) information materials linked below have been made available to me for my review and that Occupational Health staff are available for consultation.
https://occhealth.arizona.edu/programs/Screening-Tuberculosis

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This "TB Screening Questionnaire" must be completed annually to screen for your risk for tuberculosis exposure and to make the necessary recommendations for health services to protect your health and the health of others in your workplace. Please answer the following questions to be reviewed by a member of our Occupational Health staff:

1. Have you had a temporary or permanent residence (for >1 month) in a country with a high TB rate (i.e., any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe)?

☐ Yes ☐ No

If yes, please provide location and dates _____

2. Do you have immunosuppression, including human immunodeficiency virus infection, or have planned or currently are a receipt of an organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone > 15 mg/day for >1 month), or other immunosuppressive medication?

☐ Yes ☐ No

3. Have you been in close contact with someone who has had infectious TB disease since your last Annual TB Questionnaire or your last TB test?

☐ Yes ☐ No

4. Please indicate if you currently are experiencing any of the following symptoms. Please check all that apply.

Please select "NONE OF THE ABOVE" if you do not have any of the symptoms listed below:

☐ Bad cough that has lasted 3 weeks or longer

☐ Pain in the chest

☐ Coughing up blood or sputum (phlegm from deep inside the lungs)

☐ Weakness or fatigue

☐ Unexplained weight loss

☐ No appetite

☐ Chills

☐ Fever

☐ Sweating at night

☐ NONE OF THE ABOVE

Please provide further details on any of the above symptoms you have reported:

5. Have you ever received the Bacillus Calmette-Guercin (BCG) vaccine for Tuberculosis (TB)?
   ☐ Yes ☐ No
6. Have you ever had a positive skin test or TB blood test?
   ☐ Yes ☐ No
7. Have you ever been diagnosed with **active** TB?
   ☐ Yes ☐ No
   7a. If Yes, please indicate medication taken for TB Treatment: _____
   7b. If Yes, when was your last chest X-ray? Indicate date: _____
   7c. Was the result of your last chest X-ray normal or abnormal?
      ☐ Normal Chest X-Ray
      ☐ Abnormal Chest X-Ray
8. Have you ever been diagnosed with **latent** TB?
   ☐ Yes ☐ No
   8a. If Yes, did you receive TB drug treatment?
      ☐ Yes, please indicate medication: _____
      ☐ No
   8b. When was your most recent chest X-ray? Indicate date: _____
   8c. Was the chest X-ray normal or abnormal?
      ☐ Normal Chest X-Ray
      ☐ Abnormal Chest X-Ray
9. Would you like to speak to a healthcare provider about Tuberculosis or the information on this form?
   ☐ Yes ☐ No
10. Do you have any additional questions about Tuberculosis exposure, risk factors, or screening?
    ☐ Yes ☐ No

By submitting this form, I certify that the information I have provided is correct and *I acknowledge that I have had the opportunity to review the Occupational Health Program's Privacy Practices available at the following link:*
https://occhealth.arizona.edu/general-consent-privacy-practices

Signature: _____

Today's Date: _____

Once you have completed the form:

Save a copy of this PDF and either email it to Occupational Health at occhealth-support@arizona.edu or fax it to our secure fax line at 1-833-407-1266.