

## McLaren Print System Order

Order No: 63258 Reprint Previous Order No: 5562  
 Order Date: 2021-06-28  
 User: Kristin Fudge  
 Phone: 9893932850

Ship Location: McLaren Bay Uptown Occupational Health  
 4 Columbus Ave STE 140  
 Bay City, mi 48708

### Forms

Quantity: 100  
 Paragon Dept No: 69100  
 Dept Name: Bay Uptown Occupational Health  
 Company Number: 810

Order Total Price: 11.80

Item Number: MM-34078  
 Item Description: TB Screening Questionnaire  
 Revision Date: 8/2013  
 Print: 1 sided black and white  
 Paper: 2 Part (White, Yellow)  
 Size: 8.5 x 11  
 Fold:  
 Finish:  
 Drill: None  
 Misc Info:

McLaren Medical Group  
**TB Screening Questionnaire**

Employee Use Only:  
 Dept: \_\_\_\_\_  
 New Hire  Semi-Annual  Annual  Post Positive Questionnaire  
 Post Exposure Date: \_\_/\_\_/\_\_

Please read and answer the following questions very carefully.

- Have you ever been told you had TB?  Yes  No
- Have you ever lived with anyone with TB?  Yes  No
- Have you had close contact with a person with TB?  Yes  No
- Have you ever had a positive TB test?  Yes  No
- Have you taken TB medications after a positive TB test?  Yes  No
- Have you received a live shot vaccine in the past 4-6 weeks?  Yes  No
- Were you born outside of the United States?  Yes  No
- Have you traveled outside of the United States (other than Canada, New Zealand, Western Europe or Australia)?  Yes  No
- Have you ever received BCG vaccinations?  Yes  No
- Have you ever lived in a long term care, correctional facility, or shelter?  Yes  No
- Have you had close contact with someone who was in a Long Term Care Facility, Correctional Facility or Shelter within the last 5 years?  Yes  No
- Have you ever injected illicit drugs?  Yes  No
- Are you frequently exposed to anyone who injects illicit drugs?  Yes  No
- Are you frequently exposed to migrant farm workers?  Yes  No
- Have you had contact with anyone coming from a foreign country?  Yes  No
- Have you had a recent anal infection?  Yes  No

Please check if you have any of these symptoms (symptoms of TB) and DO NOT know the cause:  
 Cough with sputum or blood for more than 2 weeks  Night sweats  Shortness of breath  
 Unexplained weight loss/Appetite loss  Fever/Chills  Fatigue  Chest pain

Please check if you have the following health problems or are taking any of these medications:  
 Any immune-compromising conditions  Currently taking steroids  
 Currently taking Chemotherapy  HIV positive or at risk for HIV

By signing in the space below, I am agreeing to the following statements:  
 > To the best of my knowledge, I have answered all of the above questions correctly  
 > I understand the TB screening program and need to have my test read in 48 to 72 hours. If I do not return within 72 hours, I will need to have the test re-done.  
 > (For employees only) I agree to inform the Employee Health Nurse, if I develop any symptoms of TB before my next TB screening.

Patient/Employee/Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

- Risk Evaluation:**  
 Test immediately  
 Test immediately and annually while risk exists  
 Begin treatment  
 No risk, no testing needed

Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_