UFHealth
UNIVERSITY OF FLORIDA HEALTH

Tuberculosis **(TB)** Surveillance Form - Occupational Health Services

Name_____ Department_____

UFID#_____ Title_____

Date of Birth _____ Phone Number_____

Please answer all of the following questions and sign below.

1. Have you had any of the following symptoms/signs associated with active TB?

	No	Yes	If YES, length of time
A persistent cough longer than 2 weeks (especially in the presence of)	☐	☐	_____
Recent unexplained weight loss	☐	☐	_____
Night sweats	☐	☐	_____
Bloody Sputum	☐	☐	_____
Loss of appetite	☐	☐	_____
Fever	☐	☐	_____

You must be evaluated promptly if you have or develop any signs or symptoms of active Tuberculosis.

2. Do you currently have a disease or take medication that causes your immune system to be suppressed [i.e. chemotherapy, steroids, Remicade (Infliximab), Humira (adalimumab), or Enbrel (enteracept)]?

☐ No ☐ Yes (If Yes, discuss with Employee Health nursing staff)

3. Have you had live virus vaccine (measles, mumps, rubella, varicella) in the last 6 weeks? ☐ No ☐ Yes

4. Have you ever had a positive TB skin test, TB-IGRA or Quantiferon TB Gold? ☐ No ☐ Yes

5. Have you ever been treated for a TB or a positive TB test? ☐ No ☐ Yes If yes, discuss with the nurse.

If yes, length of treatment_____ Name of medication _____

6. Have you received a BCG vaccination in the past? ☐ No ☐ Yes

7. Have you lived outside the United States for any period of time? ☐ No ☐ Yes

Where?_____ When? _____

8. Since your last TB screening, have you had unprotected direct contact with a person with active tuberculosis? ☐ No ☐ Yes

9. New employees only: Have you had a TB test in the last 12months? ☐ No ☐ Yes If Yes, provide documentation.

TB skin test must be read in 48 to 72 hours

Signature _____ Date_____

Do Not Write Below This Line

Type: ☐ Pre-placement ☐ Two-step ☐ Exposure ☐ Baseline ☐ 10-12 weeks ☐ 6 mo. ☐ 12 mo. ☐ Annual Surveillance

Other_____

1. TB Skintest Applied:_____ Results_____ ☐ - ☐ +

Date/Time. Site Date/Time MM

Lot#_____ Expiration Date:_____

_____

Healthcare Provider Signature

_____

Healthcare Provider Signature

2. Quantiferon TB Gold _____ _____

Date/Time · Result

_____

Healthcare Provider Signature