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# TUBERCULOSIS SCREENING FORM (2000)

Clear Form

Please have this form completed properly, then submit it to the worksite whose payroll Turnaround Document lists your name by _____. This is necessary to comply with Section 25103, Title 10, Guam Code Annotated, which requires you to be screened for tuberculosis as a condition of employment or doing volunteer work, and annually thereafter. Failure to do so by the date given above can be grounds for placing you on leave without pay until the required documentation is submitted.

Please note the following:

- The items on this form require that they be completed within a certain time period to be valid. Different items have different time periods.
- Applicants for employment must first submit a copy of this form to the Personnel Services Division, then, upon hiring, also provide a copy to the stated worksite.

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Name Of Employee _____ DOB: _____
(last) (first) (middle)

Social Security # _____ Work location _____

## DIRECTIONS

Completely read the following items and do what is indicated by them; many require you to continue to another item. Items shown in small print must be completed by a physician, physician's assistant (PA), nurse practitioner (NP), or nurse; refer to each item for specifics.

1. If you are not a positive TB test reactor: start with Item 2.

   If you are a positive TB test reactor but have not received treatment for Tb, start with Item 6.

   If you are under or have received treatment for TB: do Item 9.

2. Obtain a PPD skin test and have the following information completed. Then do Item 3. (The results must be less than a year old on the date at the top to be valid. You may attach other medical documentation to this form which shows the date of administration and reading of a PPD instead of having this item completed. However, all other items which apply to your situation must be properly completed ~~on this form.)~~

   Date administered:_____ Date read:_____ Result:_____ mm

   _____ _____
   Name of physician/PA/NP/nurse (print) Signature of physician/PA/NP/nurse

3. a) If the result from Item 2 is 0-9 mm or negative, disregard the following items.

   b) If the result of Item 2 is 10 mm or greater: do Item 4.

4. Obtain a chest X-ray and: a) have the following completed by only a physician, PA, or NP; and b) attach a radiology report concerning the X-ray from a licensed radiologist. Then do Item 5. (If this is done in compliance with Item 3: the X-ray must have been conducted no sooner than six months prior to the PPD required by Item 2 to be considered valid. If this is done in compliance with Item 6: the X-ray must have been conducted no sooner than six months prior to the date shown at the top of the other side to be considered valid.) If you are pregnant: do Item 7 if you are less than 20 weeks pregnant (in this case Item 7 may be completed only by a physician); otherwise, do this item, then Item 5 (tell the clinic you need an abdominally shielded X-ray because of your pregnancy).

1) Are X-ray results suggestive of TB? yes ___ no ___

2) Date the X-ray was administered: _____

3) Is patient currently on INH preventive therapy? yes ___ no ___

If not, please state reason:

___ patient refuses INH therapy offered
___ patient over 35 years of age with no risk factor
___ patient referred to DPHSS for possible INH therapy
___ patient referred to DPHSS for possible active TB

other _____

_____ _____

Name of physician/PA/NP (print) Signature

5. a) If the answer to Item 4.1 is "no": disregard the following items.
b) If the answer to Item 4.1 is "yes": do Item 9.

6. a) If the last time you had a chest X-ray was during or before 1995: do Item 4.
b) If you had a chest X-ray after 1995 and had submitted its radiology report with Item 4 properly completed to DOE for a previous Tb screening: do Item 7. Otherwise, do Item 4.

7. Have the following item completed by only a physician, physician's assistant, or nurse practitioner. Then do Item 8. (This item must have been completed no sooner than one year prior to the date shown at the top of the other side to be be valid.)

Does the person named on Side 1 have any of the following?

A) Chronic cough: (2 weeks duration or longer) ___ yes ___ no
B) Chronic cough with sputum ___ yes ___ no If yes, color of sputum _____
C) Coughing blood: ___ yes ___ no
D) Persistent night sweats: ___ yes ___ no
E) Involuntary weight loss: ___ yes ___ no
F) Unexplained fevers: ___ yes ___ no

_____ _____ _____

Name of physician/PA/NP (print) Signature Date

8. a) If all of the symptoms A-F in Item 7 were answered "no": disregard the remaining items.
b) If any of the symptoms A-F were answered "yes" in Item 7: do Item 4. (However, in this case the X-ray required by Item 4 will be considered valid only if it has been conducted no more than one month prior to, or anytime after, when Item 7 has been signed.)

9. Have the TB Control Section of the Department of Public Health & Social Services in Mangilao complete the following; clearances from anywhere else will not be accepted. {Call 735-7145/7157 for an appointment. When doing so, ask what documents you should bring to get cleared.} You may return to work or resume your job application process on the date indicated on the left below.

May start/return to work on: _____ DPHSS Stamp: _____

DPHSS staff signature: _____ Date: _____