



Occupational
Medicine
Services

Bethesda Care Arrow Springs
Phone: 513-282-7075
Fax: 513-282-7076

Bethesda Care Butler County
Phone: 513-874-3990
Fax: 513-860-5071

Bethesda Care Eastgate
Phone: 513-752-3695
Fax: 513-752-3039

Bethesda Care Norwood
Phone: 513-731-3399
Fax: 513-731-2882

Bethesda Care Queensgate
Phone: 513-241-4135
Fax: 513-241-6510

Bethesda Care Sharonville
Phone: 513-563-1505
Fax: 513-769-4776

Good Samaritan
Phone: 513-862-2875
Fax: 513-862-2860

TUBERCULOSIS (TB) SCREENING

Name: _____

Date of Birth: _____

Company: _____

Today's Date: _____

	<u>YES</u>	<u>NO</u>
If female, are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had tuberculosis or been treated for tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a positive TB skin test?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, when was your last chest x-ray? _____		
If YES, are you having any of the following for three to four weeks or longer:		
1. Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
2. Production of sputum	<input type="checkbox"/>	<input type="checkbox"/>
3. Blood-streaked sputum	<input type="checkbox"/>	<input type="checkbox"/>
4. Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>
5. Fever	<input type="checkbox"/>	<input type="checkbox"/>
6. Fatigue/Tiredness	<input type="checkbox"/>	<input type="checkbox"/>
7. Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
8. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a severe reaction to TB serum?	<input type="checkbox"/>	<input type="checkbox"/>

I hereby acknowledge that tuberculin PPD is a sterile solution used as an aid in the diagnosis of tuberculosis.

I understand that by signing this form, I am releasing TriHealth Occupational Medicine staff of any and all liability from all possible claims connected with the tuberculin PPD test.

Being fully informed, I request that the tuberculin PPD test be administered to me. I understand that I must have the site read during the period from 48 to 72 hours after the injection.

Signature: _____

Date: _____

Witness: _____

Date: _____

Mantoux 0.1ml intradermally <u>Right / Left</u> inner FA _____	Mfgr. _____	Lot _____	Exp. Date _____	Administered by _____
DATE/TIME GIVEN: _____	READ BY: _____			
DATE/TIME READ: _____	MM INDURATION: _____			

Mantoux 0.1ml intradermally <u>Right / Left</u> inner FA _____	Mfgr. _____	Lot _____	Exp. Date _____	Administered by _____
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Comments: _____