

QUALITY ONE CARE HOME HEALTH INC.

T. B. TEST FORM

NAME _____ PHYSICIAN _____

ADDRESS _____

TELEPHONE _____ BIRTHDATE _____ SEX ___ M ___ F

SUPERVISOR _____

The Tuberculin Test is a skin test that tells if a person has been exposed to tuberculosis. The test can discover an infection early, before any damage can be seen by x-ray. Spread of tuberculosis can be prevented by finding unknown cases with the test. Re-testing or x-ray, as appropriate, will be available for all persons who have positive tests. Rarely, persons with positive skin tests experience uncomfortable swelling and redness at the area of the skin test.

I have read the above information and hereby consent to and therefore request the provisions of services encompassing routine procedures and actions as are necessary and desirable in the exercise of professional judgment. I acknowledge that no guarantees have been made to me as to the result of the procedures and actions taken. Such consent is given to Infiniti Home Health Care, LLC for provision of services to the individual listed above.

Signature _____ Date _____

Witness _____ Date _____

----- FOR CLINIC USE ONLY -----

Test date/time Site Signature Read (Circle one) 48 hrs / 72 hrs Signature

(Dose manufacturer _____ Lot# _____ Exp. Date _____)

Test date/time Site Signature Read (Circle one) 48 hrs / 72 hrs Signature

(Dose manufacturer _____ Lot# _____ Exp. Date _____)

----- RESULTS OF TUBERCULIN TESTS -----

This is to certify that a Tuberculin Test was done for _____

Initial test was done on _____ Result was _____ Nurse's Signature _____

Second Test was done on _____ Result was _____ Nurse's Signature _____

COMMENTS/ACTION TAKEN:

Infiniti Home Health Care, LLC

TB Screening

Employee: _____

Do you currently have any of the following that has lasted three (3) weeks or longer?

- | | | | | | |
|----|-------------------------------|-----|--------------------------|----|--------------------------|
| 1. | Unexplained productive cough? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 2. | Unexplained weight loss? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 3. | Unexplained appetite loss? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 4. | Unexplained fever? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 5. | Night sweats? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 6. | Shortness of breath? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 7. | Chest pain? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 8. | Increased fatigue? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 9. | Bloody sputum? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

Have you ever:

- | | | | | | |
|----|---|-----|--------------------------|----|--------------------------|
| A. | Ever been told you have TB? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| B. | Lived with anyone with TB? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| C. | Had a positive TB skin test? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| D. | Had a BCG vaccination? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| E. | Date of last negative PPD skin test result: ___/___/___ | | | | |

Employee Signature

Date

EMPLOYER REVIEW:

I) If the employee answers yes to any question 1-9 document the objective reason for the symptom. If there is no known reason for the symptom lasting 3 weeks or longer the employee is to have a TB skin test.

II) If the employee answers yes to any question A-B, the employee is to have a TB skin test.

III) If the employee answers yes to question C the employee is to have either a chest x-ray or a physician statement noting the employee is free from communicable disease.

The following apply to this employee: (Circle one or more) I II III None

Administrative Review Completed by: _____ Date: _____