VASDHS Occupational Health Tuberculosis Surveillance Form

Date	
LAST Name	
FIRST Name	
MIDDLE Name (FULL)	
Full Social Sec #	
Date of birth	
VA Service/Dept.	
Best Email	

Return this form to Occupational Health Via:

Encrypted Email to: SDCVAMC OH TB & Clearance Forms

Confidential Guard Mail to: 11-OCC

Fax to: 858-552-4368

Drop Off: Administration Building (Building 27), Room 1105

☐ MALE ☐ FEMALE

POSITION: ☐ Paid VA ☐ Volunteer ☐ WOC ☐ Work Study

Contact Info: VA Extension:_____Pager/Cell:_____ Alternate E-mail:_____

EMPLOYEE TO COMPLETE ALL FIELDS BELOW

Do you currently have any of the symptoms below:
☐ Yes ☐ No

Mark any of the following symptoms you currently have:
☐ Fever
☐ Chills
☐ Cough
☐ Coughing up blood
☐ Fatigue
☐ Unintentional weight loss

Have you ever had a TB skin test?
☐ Yes ☐ No

Have you ever had a TB blood test?
☐ Yes ☐ No

If yes, approx. date of last test:_____

If yes, where was it done:
_____

Have you ever had BCG vaccine?
Yes No

Have you ever had a positive TB test?
☐ Yes ☐ No

Have you ever had active Tuberculosis?
☐ Yes ☐ No

Were you treated with INH? If yes, for how long?
☐ **Yes** ☐ No ☐ **3 mo.** ☐ **6 mo.** ☐ **9 mo.**

If you have had a positive TB skin test, positive TB blood test, or active tuberculosis:

Approximate date (year): ☐ N/A

Location of last TB test or where you were treated for TB: ☐ N/A

Approximate date (year) and location of last chest x-ray: ☐ N/A

PAID VA EMPLOYEES ONLY: Tetanus, Diphtheria, and Pertussis Screening (Tdap)

For prevention of tetanus, diphtheria, and pertussis (Whooping Cough), ACIP recommends adults receive a one-time booster dose of Tdap. Tdap can be administered regardless of interval since the last tetanus or diphtheria toxoid.

Have you received a booster dose of Tdap? ☐ **Yes** ☐ **No** ☐ **Not Sure**

If you have not received a booster dose or if you are not sure, would you like one? ☐ **Yes** ☐ **No**

FOR OCCUPATIONAL HEALTH USE ONLY

MEASLES TITER	RUBELLA TITER	QUANTIFERON TITER
Date:	Date:	Date:
Results: ☐ Negative ☐ Positive	Results: ☐ Negative ☐ Positive	Results: ☐ Negative ☐ Positive
MUMPS TITER	**VARICELLA TITER**	**CHEST X-RAY**
Date:	Date:	Date:
Results: ☐ Negative ☐ Positive	Results: ☐ Negative ☐ Positive	Results: ☐ Negative ☐ Positive

Follow up: ☐ **None Required** ☐ **Refer to Personal Provider** ☐ **Refer to VA Provider/TB Nurse** ☐ **Occ Health**

Lab Order #: **Date:**

Comments:

Last Modified: April 11, 2016