VASDHS Occupational Health Tuberculosis Surveillance Form

Volunteer Quantiferon Order PRINT CLEARLY

Date:	
First Name:	
Middle Name:	
Last Name:	
Full Soc Sec # :	____ ____ ____ - ____ ____ - ____ ____ ____ ____
Date of birth:	
Department/Service:	VOLUNTEER SERVICE
Sex:	☐ Male ☐ Female

Reason For Test: ☐Baseline ☐Annual		
Contact Info: Home/Cell Phone: _____ Pager: _____ Email:		
TB SYMPTOM REVIEW	**TUBERCULOSIS HISTORY**	
☐No symptoms	☐History of negative PPDs	☐History of BCG vaccine
☐Fever	Date of last PPD:	☐History of positive PPD *
☐Chills	Where PPD done:	☐History of positive Quantiferon *
☐Cough (persistent)		☐History of active TB*
☐Coughing up blood	*** If hx of positive PPD, positive Quantiferon, or active tuberculosis:**	
☐Fatigue	When:	
☐Unintentional wt loss	Where:	
Other:	Treatment:	
	Date of last chest x-ray:	
	Location of last chest x-ray:	

SIGNATURE:_____ DATE:_____

BELOW TO BE COMPLETED BY OCCUPATIONAL HEALTH STAFF ONLY:

Clearance Date: OH Signature:

----------OFFICE USE----------

☐ Vaccine or Titer Records ☐ VISTA

☐ TB Results (Other Facility) ☐ OHM

☐ Consent (Minors Only)