



Resource Family Approval (RFA)



TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE for

_____ County or Agency

Instructions: To be completed by each adult residing in an Resource Family home and reviewed and signed by a licensed health professional.

Patient Name: _____ Date of birth: _____ Male Female

Address: _____
Street Apartment # City Zip code

Telephone: _____
Home Work Cell

Country of birth: _____ Race/Ethnicity: _____ US arrival date (if applicable): _____

Travel outside the United States in the last 2 years: Yes No If yes list country _____

Visitors from outside the United States in the last 2 years: Yes No If yes, list country _____

Please check one answer or fill in the blank:

1. Have you ever had a Bacille Calmette-Guérin (BCG) vaccine for tuberculosis (TB) disease? Yes No Unknown
a. BCG dates: _____
2. Have you ever had a TB skin test? Yes No Unknown
If YES, please provide:
a. TB skin test date(s): _____
b. TB skin test results Negative Positive Unknown
3. Have you ever been told that you had TB infection or disease? Yes No Unknown
4. Did you ever take TB medication? Yes No Unknown
If YES, please provide:
a. Name of the medication(s), number of pills and dates of treatment:

b. Name of clinic where you were treated? _____
5. Do you currently have any of the following signs and symptoms of active TB disease?
 - a. Persistent cough longer than two weeks duration Yes No
 - b. Coughing up blood Yes No
 - c. Hoarseness Yes No
 - d. Fever Yes No
 - e. Sweating at night Yes No
 - f. Unexplained weight loss Yes No
 - g. Unexplained excessive fatigue Yes No
 - h. Other unusual symptoms: _____

- 6. Were you immunized **within the last 6 weeks** for measles, mumps or rubella? **Yes** **No**
- 7. Are you undergoing any treatment, or do you currently have a medical condition, that could weaken your immune system?
(Describe) _____
- 8. Do you have diabetes? **Yes** **No** **Unknown**
If YES, please provide name of medication(s): _____

To be filled out by a licensed health professional:

- 9. Based on the information provided I determine the patient's risk of TB infection is **LOW** **HIGH**
 - a. **If HIGH, please list any follow up required:** _____

FOR LICENSED HEALTH PROFESSIONAL ONLY	
DATE EXAMINED	SIGNATURE OF LICENSED HEALTH PROFESSIONAL
TELEPHONE NUMBER	PRINTED NAME OF LICENSED HEALTH PROFESSIONAL
ADDRESS OF LICENSED HEALTH PROFESSIONAL	