Volunteer TB Risk/Symptoms & Health Assessment Questionnaire (Annual)

Name of Volunteer: ______________________________ Date: ______________
(Please Print)

A. IN THE PAST 12 MONTHS, HAVE YOU HAD THE FOLLOWING WITH NO KNOWN CAUSE:

1. Unexplained or productive cough, lasting 3 weeks or more? □ Yes □ No
2. Unexplained blood tinged sputum? □ Yes □ No
3. Unexplained fever, chills or night sweats? □ Yes □ No
4. Unexplained weight loss? □ Yes □ No
5. Unexplained fatigue? □ Yes □ No
6. Chest pain? □ Yes □ No
7. Exposure to a known TB patient? □ Yes □ No
8. Recurrent or unexplained shortness of breath? □ Yes □ No
9. Unexplained hoarseness. □ Yes □ No
10. Recurrent pneumonia? □ Yes □ No
11. Birth, travel, or residence for at least one month, to any country other than the US, Canada, New Zealand, Australia, Northern Europe, or Western Europe? □ Yes □ No
12. Do you currently or have planned Immunosuppression (Medical condition or taking medications which suppress your immune system) such as: HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication □ Yes □ No

B. If at any time during the 12-month period between TB screens you experience symptoms of potential TB, or have a significant change in your health status, you agree to immediately notify the Clinic Operations Manager or the Medical Director. □ Yes □ No

C. Previous BCG? □ Yes □ No

D. Any current communicable (i.e., contagious) disease ? □ Yes □ No
If yes, explain:

1st Volunteer Signature____Date:__________________

TO BE COMPLETED AND SIGNED BY ROTACARE CLINICIAN: (RN OR MEDICAL PROVIDER)

Name of RotaCare Clinician____
Please Print Name

Upon review of the responses to the questionnaire and discussion with the volunteer:

I verify that this Volunteer is able to perform his/her assigned duties and does not have any health condition that would create a hazard for the volunteer, fellow volunteers, patients or visitors. □ Yes □ No

Further evaluation, including a TB Skin Test, Interferon Gamma Release Assay or other medical evaluation is indicated, and should be completed prior to Volunteering for RotaCare Bay Area, Inc. □ Yes □ No

PPD or Quanitferon Gold? □ PPD □ QG

Other recommendations (e.g., CXR for newly positive TB test, or follow-up with PCP):
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RotaCare Clinician Signature:___________________________________Date:______________________

2nd Volunteer Signature: ___________________________________Date: __________________