**Volunteer TB Risk/Symptoms & Health Assessment Questionnaire**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Unexplained or productive cough, 3 weeks or more? □ Yes □ No

2.  Unexplained blood tinged sputum, at any time? □ 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. 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.   Immunosuppression, current or planned: (i.e., Medical condition or taking medications which suppress your immune system) □ Yes □ No

13. 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

 14. Newly positive TB test (PPD skin test or Quanitferon TB Gold)? □ Yes □ No

B. If at any time during the 12-month period between TB screens you experience symptoms of potential TB, do you agree to immediately notify the Clinic Operations Manager or Medical Director.

 □ Yes □ No

C. Previous BCG vaccine? □ Yes □ No

D. Any current communicable (i.e. contagious) disease? □ Yes □ No

If yes, explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Volunteer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

(Q TB Gold recommended if history of BCG vaccine)

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

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Signature of Clinician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Volunteer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_