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	