

**LATENT TUBERCULOSIS INFECTION (LTBI)
QUESTIONNAIRE**

**PLEASE SUBMIT FOR CLEARANCE REQUEST FOR PATIENTS HAVING POSITIVE TB
SKIN TEST**

NAME		DOB _____/_____/_____
ADDRESS		
ETHNICITY		PHONE NUMBERS: (HOME/WORK/MOBILE)

PPD SKIN TEST	Date given:	Date read:	Results: _____ mm
Chest X-Ray <small>(Copy of report MUST Be Attached)</small>	Date of CXR exam:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments: _____ _____
LTBI Treatment	Date treatment started:	Date completed:	<input type="checkbox"/> No h/o treatment
	Adverse reactions to LTBI therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO		Patient declined therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO

Have you been exposed to active TB? <input type="checkbox"/> YES <input type="checkbox"/> NO			
SYMPTOMS	YES	NO	<p><i>If response is "yes" to any of the symptoms, patient will need a repeat 2 view CXR before referral to Public Health for clearance.</i></p> <p>Please include findings from repeat CXR (Copy of report <u>MUST</u> be attached):</p> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Cough			
Fever			
Weight loss			
Night sweats			
Fatigue			
Chest pain			
Shortness of breath			
Hoarseness			

Patient is cleared for work/school	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient is referred to the Department of Public Health Communicable Disease Clinic for possible active tuberculosis (All required documents <u>MUST</u> accompany referral).	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Physician Signature/Stamp

Name of Physician/Clinic

Date (Valid 90 days)

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
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