# TB ANNUAL RECORD

continuum
REHABILITATION LLC

Employee Name: ___________________________________

Date completed: ___________________________________

| QUESTION | YES | NO |
|---|---|---|
| 1. Have you ever had a positive TB skin test? If yes, date of last positive TB skin test (mm-dd-yy) _____________________ | ☐ | ☐ |
| 2. Have you ever received INH (isoniazid)? | ☐ | ☐ |
| 3. Have you received a polio or measles vaccine within the past two months? | ☐ | ☐ |
| 4. Are you taking any medications that would affect this reading (i.e. steroids, anti-viral protease inhibitors, immunosuppresants)? | ☐ | ☐ |
| 5. Do you have any chronic medical conditions that would effect this reading (heart disease, diabetes, kidney disease)? | ☐ | ☐ |
| 6. Have you ever received a BCG vaccination? | ☐ | ☐ |
| 7. Have you been diagnosed as having tuberculosis? | ☐ | ☐ |
| 8. Do you have any sign or symptoms of the following: | | |
| Cough lasting longer than 3 weeks | ☐ | ☐ |
| Coughing up blood | ☐ | ☐ |
| Fever lasting longer than 3 weeks | ☐ | ☐ |
| Night sweats | ☐ | ☐ |
| Unintentional weight loss | ☐ | ☐ |

FOR ALL EMPLOYEES: Should I experience any of the above symptoms, I must immediately contact Continuum Rehabilitation, LLC. I understand that I may retain a copy of this form for my records.

Employee Signature: _______________________________ Date: ____________________

## PPD Annual Test Results

Date applied: ______________________ Tested by: _______________________________

Date read: _________________________ Read by: _________________________________

Induration: __________________ mm

** Induration of 10mm (width) or greater is considered positive for all health care workers of any age**

| | | |
|---|---|---|
| Referred for Chest X-Ray | YES | NO |
| Referred for Medical Follow up | YES | NO |