EMPLOYEE: PLEASE FILL OUT BOTH PAGES

UCLA Health System

Occupational Health Facility
10833 Le Conte Ave, CHS 67-120
Los Angeles, CA 90095-1725
(310) 825–6771
Occupationalhealth@mednet.ucla.edu

Tuberculosis Screen

Staff Member to complete the top half of page and sign.

Employee Health only
TB Screen Result:
Cleared
Not Cleared
_____
Reviewer Signature
_____
Reviewer Name
_____
Date

Name: _____ **Department:** _____

DOB: _____ **Staff ID:** _____ **Phone number:** _____ **Ext:** _____

Email Address: _____

Reason for screening (check all that apply)

☐ New Staff ☐ Physician Credentialing ☐ SM Care Extender
☐ Staff Annual ☐ Volunteer ☐ Other: _____

Employee Health Only_____
TB Exposure Date _____ Baseline 8-10 wk Post Exposure_

I have a history of a positive TB Skin Test, T-SPOT or Quantiferon Blood Test (Circle one): Yes Date _____ No ☐
I have taken INH or other medication in the past for TB infection or disease: YES ☐ Dates: _____
Number of months: _____ Medication: _____NO ☐

All staff must answer the following questions EVERY year: (if you answer "yes" to any question below please return this form directly to OHF or SM Employee Health to be evaluated for safety at work)

1. Do you have

Recent Contact of a person with active Tuberculosis	Yes ☐	No ☐
Any condition that decreases your immune system	Yes ☐	No ☐
An Organ Transplant	Yes ☐	No ☐

2. Since your last TB Test, have you had any of the following active **TB symptoms** for **more than 3 weeks**?:

Coughing up blood	Yes ☐	No ☐	Persistent fever	Yes ☐	No ☐
Persistent coughing	Yes ☐	No ☐	Hoarseness	Yes ☐	No ☐
Excessive fatigue	Yes ☐	No ☐	Unexplained weight loss	Yes ☐	No ☐
Excessive sweating at night	Yes ☐	No ☐			

Staff member's signature: _____ **Date:** _____

Employee Health Only

TB Skin Test (annual) Date: ___/___/___ Rt_____ Lt_____ Placed By: _____

5TU dose PPD (0.1cc) Manufacturer: Aventis Sanofi Pasteur Lot Number: _____ Expiration Date: _____

Skin Test Reading Date: ____/____/____ Result: Negative _____ mm induration Positive _____mm induration

Read by: _____

New Hire Step #2
TB Skin Test Date: ____/____/____ Rt_____ Lt_____ Placed By: _____

5TU dose PPD (0.1cc) Manufacturer: Aventis Sanofi Pasteur Lot Number: _____ Expiration Date: _____

Skin Test Reading Date: _____/____/____ Result: Negative _____mm induration Positive _____mm induration

Read by: _____

Quantiferon Blood Draw Date Requested: _____/_____/_____ Result: Negative Positive Indeterminate

---

Chest X-Ray: Only for (1) new hires with a positive TST, (2) initial evaluation of new TST converters, (3) established positive TST staff that have TB symptoms, and (4) to initially evaluate any healthcare provider with ≥ 5mm induration. All staff with active TB symptoms shall be restricted from work until official radiological interpretation.

Date Requested:___/____/____ Date Reviewed:___/____/____ Result: _____
Action: _____Reviewed by: _____Date:___/__/__

Employer's Copy

UCLA Health System

Occupational Health Facility
10833 Le Conte Ave, CHS 67-120
Los Angeles, CA 90095-1725
(310) 825–6771
Occupationalhealth@mednet.ucla.edu

Recharge ID/FAU_____
(Required for non-Health System Staff)

Tuberculosis Screen

Staff Member to complete the top half of page and sign.

Employee Health only
TB Screen Result:
Cleared
Not Cleared
_____
Reviewer Signature
_____
Reviewer Name
_____
Date

Name: _____ **Department:** _____

DOB: _____ **Staff ID:** _____ **Phone number:** _____ **Ext:** _____

Reason for screening (check all that apply)

☐ New Staff ☐ Physician Credentialing ☐ SM Care Extender
☐ Staff Annual ☐ Volunteer ☐ Other: _____

Employee Health Only_____
TB Exposure Date _____ Baseline 8-10 wk Post Exposure_

---

o