TUBERCULOSIS SCREENING FORM
2021

Please have this form completed properly, then submit it to the worksite whose payroll lists your name by _____. This is necessary to comply with Section 25103, Title 10, Guam Code Annotated, which requires you to be screened for tuberculosis as a condition of employment or doing volunteer work, and annually thereafter. Failure to comply can and will be grounds for placing you on leave without pay until the required documentation is submitted.

Please note the following:

- The items on this form require that they be completed within certain time Period to be valid. Different items have different time periods.
- Applicants for employment must first submit of this form to the Personnel Services Division before beginning work.

Name of Employee/Volunteer: _____ D. O. B. _____

Social Security #: _____ Work Location/Dept.: _____

DIRECTIONS

Directions: *Completely read the following items and do what is indicated by them; many require you to Continue to another item. Items shown in small print must be completed by a Physician, Physician's Assistant (PA), Nurse Practitioner (NP), or Nurse; refer to each item for specifics.*

1. If you are not a positive TB test reactor, start wit Item 2.
   If you are a positive TB test reactor but have not received treatment for TB, start with Item 6.
   If you are under or have received completed treatment for TB: do Item 9.

2. Obtain a PPD skin test and have the following information complete. Then do Item 3.
   (The results must be less than a year old on the date at the top to be valid. You may attach other medical documentation to this form with shows the date of administration and reading of a PPD instead of having this items completed. However, you are still responsible for having all other items which apply to your situation properly completed on this form.).

Date administered: _____ Date read: _____ Results: _____ mm

_____ _____
Name of Physician, PA/ Nurse (print) Signature of Physician, PA/ Nurse

3. a) If a result from Item 2 is 0-9mm or negative, disregard the following items.
   b) If the result from Item 2 is 10mm or greater: do Item 4

4. Obtain a chest X-ray and: a) Have the following completed by only a Physician, PA, or NP; and b) Attach a radiology report concerning the X-ray from a licensed radiologist. Then do Item 5. (If this is done in compliance with Item 3: the X-ray must have been conducted no sooner than in six months prior to the PPD required by item 2 to be considered valid. If this is done in compliance with Item 6: the X-ray must have been conducted no sooner than six months prior to the date shown at the top of the other side to be considered valid). If you are pregnant, do Item 7 if you are less than 20 weeks pregnant (in this case Item 7 may be completed only by a Physician); otherwise, do this item, then Item 5 (tell the clinic you need an abdominally shielded X-ray because of your pregnancy).

   1.) Are X-ray results suggestive of TB? [ ] yes [ ] no

   2.) Date the X-ray was administered: _____

   3.) Is the patent currently on INH prevention therapy? [ ] yes [ ] no

continued. . .

If not, please state reason:

[ ] Patient refused INH preventive therapy offered

[ ] Patient over 35 years of age with no risk factor

[ ] Patient referred to DPH&SS for possible INH preventive therapy

[ ] Patient referred to DPH&SS for possible active TB

Other: _____

_____ _____

Name of Physician, PA/NP/Nurse (print) Signature of Physician/PA/NP/Nurse

5. a.) If the answer to Item 4.1 is "no", disregard the following items.
b.) If the answer to Item 4.1 is "yes", do Item 9

6. a.) If the last time you had a chest X-ray was during or before 2005: do Item 4.
b.) If you had a chest X-ray after 2005 and had submitted its radiology report with Item 4 properly completed to the University of Guam for a previous TB screeing: do Item &. Otherwise, do Item 4.

7.) Have the following item completed by only a Physician, Physician's Assistant (PA), or Nurse Practitioner (NP). Then do Item 8. (This item must have been completed no sooner than one year prior to the date shown at the top of the other side to be valid.)

Does the person name on page 1 have any of the following?

A.)	Chronic cough: (Two (2) weeks duration or longer)	[ ] YES [ ] NO
B.)	Chronic cough with sputum	[ ] YES [ ] NO If yes, color of sputum _____
C.)	Coughing Blood	[ ] YES [ ] NO
D.)	Persistent night sweats	[ ] YES [ ] NO
E.)	Involuntary Weight Loss	[ ] YES [ ] NO
F.)	Unexplained fevers	[ ] YES [ ] NO

_____ _____

Name of Physician/PA/NP (print) Signature of Physician/PA/NP

8. a.) If all of the symptoms A-F in Item 7 were answered "no", disregard the remaining Items.
b.) If any of the symptoms A-F were answered "yes" in Item 7: do Item 4. (However, in this case the X-ray required by Item 4 will be considered valid only if it has been conducted no more than one month prior to, or anytime after, when Item 7 has been signed).

9. Have the TB Control Section of the Department of Public Health & Social Services in Mangilao complete the following: clearances from anywhere else will not be accepted (Call 735-7145/7157 for an appointment. When doing so, ask what documents you should bring to get cleared).You may return to work or resume your job application process on the date indicated on the left below.

May start/return to work on: _____ DPH&SS stamp:_____

DPH&SS Staff Signature: _____Date: _____

TUBERCULOSIS (TB) EVALUATION FORM

PLEASE SUBMIT FOR CLEARANCE REQUEST FOR PATIENTS HAVING POSITIVE TB INFECTION

NAME	_____	**DOB:**	_____
HOME ADDRESS:	_____	**ETHNICITY:**	_____
MAILING ADDRESS:	_____	**PHONE NUMBERS:** (Home/Work/Mobile)	_____

PPD SKIN TEST	Date given:_____ Date read: _____ Result:_____ Reading: _____mm
IGRA TEST	Date given:_____ Test Type: _____ Result: _____

Has the patient been exposed to active TB in the last (2) years? *Yes* *No*

SYMPTOMS ≥ 2 WEEKS	**YES**	**NO**
Cough		
Fever		
Weight loss		
Night sweats		
Fatigue		
Chest pain		
Shortness of breath		
Hoarseness		

DOES THE PATIENT HAVE A HISTORY OF:

Cancer Yes No Type: _____

Hepatitis Yes No

Kidney Disease Yes No On dialysis? Yes No

Rheumatoid Arthritis (Joint Pain) Yes No

HIV/AIDS Yes No On medications? Yes No

Other/Note: _____

If response is "yes" to any of the symptoms or CXR is abnormal, patient will need a repeat (2) view CXR or follow the Radiologist' recommendations before referral to Public Health for clearance

Chest X-ray

(copy of report **MUST** be attached)

Date of CXR: _____ Normal / Abnormal

Comments: _____

REPEAT CXR

(if applicable, copy of report **MUST** be attached)

Date of CXR: _____ Normal / Abnormal

Comments: _____

NOTE: If active TB is suspected, refer by call or email to the Tuberculosis/Hansen's Disease Control Program

LTBI TREATMENT: 3HP INH RIF Other: _____

Date Started:_____Date Completed:_____

Refused Date Refused _____Reason for refusing:_____

Adverse reactions to LTBI therapy? ***Yes*** ***No***

By signing this form, I,_____(Name of licensed provider (MD/NP/PA)), am certifying that I have ruled out active TB and the patient is cleared for work/school.

NAME OF CLINIC | **PHYSICIAN SIGNATURE/STAMP** | ***Date (valid 90 days)***

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
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