HEALTH CARE FOR THE HOMELESS

ADDICTION TB SCREENING /ASSESSMENT FORM

Date:	Client Date of Birth:	SS#:	Sex:	Race:

Client Address:	Phone:

Contact Person (Next of Kin:)	Phone:

I. TB HISTORY

1. Do you currently have any of the above symptoms: (Mark all that apply)

Symptoms	Yes	No	
Night Sweats7			
Fatique?			
Persistent Cough?			**If yes, refer to HCH Medical Team Leader**
Blood in Sputum?			**If yes, refer to HCH Medical Team Leader**
Unexplained Weight Loss.7			

2. Date of last TB test: _____

3. Previous history of TB disease? [ ] Yes [ ] No [ ] Unknown

If yes, Where and When _____

4. Previous Positive TB skin test? [1 Yes [ ] No [ ] Unknown

If yes, Where and When _____

5. Did you take medication? [ ] Yes [ ] No [ ] Unknown

If yes, Name and duration of treatment _____

6. History of Negative TB skin test? [1 Yes [ ] No [ ] Unknown

If yes, Where and When _____

If **greater than 12 months since last test, refer to HCH Medical Team**

II. TB RISK ASSESSMENT

	Yes	No	Unk
1. HIV Infection?			
2. History of injection drug use?			
3. Are you aware of any close exposure in last 24 months to someone with active TB?			
4. Is Client enrolled in Methadone, Intermediate Care Facility or Therapeutic Community Program?			

If answer is "No" to Questions 1, 2, 3 and 4 - referral for skintest is not needed. Do Not Complete Rest of Form

III. REFERRAL INFORMATION FOR TB SKIN TEST

Date of Referral: _____

CLIENT LAST NAME:		FIRST:		HCH#:	

IV. CONSENT FORM

The Purified Protein Derivative (PPD) test is administered annually to clients to screen for exposure to Tuberculosis. **If you have ever had a positive reaction to a tuberculosis test, you should not receive the PPD Test.**

To the best of my knowledge, the above information is complete and accurate regarding my history of Tuberculosis screening. I have reviewed the above information and have had an opportunity to ask questions. Since a medical provider must interpret the PPD results, I understand I will return to the medical clinic within three days to obtain my results. I consent to receiving the PPD screening test.

Client Signature _____ Date _____

V. FOLLOW-UP REPORT

☐ **Client received** skin test and had it read

Date Given: _____

Results: _____

☐ Client had skin test-did not return for reading

☐ Client never kept appointment for **TB screening**

VI. DECLINATION STATEMENT

I *have been assessed as needing a TB skin test, but have chosen not to have one. I do realize that I am at risk of contracting this disease.*

Signature _____ Date _____

ADDITIONAL COMMENTS:

Counselor _____ Date _____