ARIZONA WESTERN ENTREPRENEURIAL COLLEGE

AWC NURSING ASSISTANT PROGRAM

TB Surveillance

Name		Date	
Date of Birth		Email	

Review of History and Symptoms:

1. **Have you ever had active Tuberculosis (TB)?** **Yes** □ **No** □

   Year of Diagnosis:_____ Treatment:_____

2. **Have you ever had a POSITIVE TB skin test?** **Yes** □ **No** □

   Year of Diagnosis:_____ Treatment:_____

3. **Is there a reason why your TB test may be falsely negative?** **Yes** □ **No** □

   Such as steroid therapy, chemotherapy, HIV, or other conditions that would compromise your ability to fight infection.

4. **Have you had any of the following symptoms during the past year?**
   a. Unexplained fevers **Yes** □ **No** □
   b. Persistent cough greater than 3 weeks **Yes** □ **No** □
   c. Coughing up blood **Yes** □ **No** □
   d. Unexplained weight loss **Yes** □ **No** □
   e. Excessive fatigue **Yes** □ **No** □
   f. Night Sweats **Yes** □ **No** □

You Must have your TB Skin Test read in 48-72 hours **Otherwise it must be repeated**

Student Signature:_____Date:_____

Date Placed:		Time:	Site: R__ L__ FA
Lot#		Expiration Date:	Initials:
Date Read:		Time:	
Erythema (mm):		Induration (mm):	Initials:

□ **Pass**-No Significant Risk of Tuberculosis (TB)

□ **Fail**-Concerning Findings—Recommend Follow Up Evaluation

Provider Signature:_____ Date:_____