TUBERCULOSIS SCREENING FORM

Ship Name: _____ Date: _____ (e.g. 01-Apr-2016)

Family Name: _____ First Name: _____

Date of Birth: _____ (e.g. 01-Apr-2016) Sex: Male ☐ Female ☐

Crew ID: _____ Nationality: _____

Crew Rank: _____ Country of Residence: _____

1) SYMPTOM QUESTIONNAIRE	ONSET DATE (e.g. 01-Apr-2016)	YES	NO	COMMENTS
1a) Shortness of Breath:		☐	☐	
1b) Cough:		☐	☐	
1c) Fever:		☐	☐	
1d) Night Sweats:		☐	☐	
1e) Weight Loss:		☐	☐	
1f) Recent Contact with TB Case:		☐	☐	
1g) Past Treatment for TB:		☐	☐	
1h) Last CXR Date:		(e.g. 01-Apr-2016)		
1i) PEME Medical Fitness Exam:		(e.g. 01-Apr-2016)		
1j) BCG Vaccination Date:		(e.g. 01-Apr-2016)		
1k) BCG Scar: ☐ Yes ☐ No	Site:			

2) MANTOUX SKIN TESTING	TEST 1		TEST 2	
2a) Date Performed:		(e.g. 01-Apr-2016)		(e.g. 01-Apr-2016)
2b) Date Read (48-72 hours):		(e.g. 01-Apr-2016)		(e.g. 01-Apr-2016)
2c) Result in mm:		mm		mm

3) CHEST X-RAY TESTING		
3a) Chest X-Ray Date:		(e.g. 01-Apr-2016)
3b) Chest X-Ray Interpretation:		

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4) RESULTS OF SCREENING					
4a)	☐	Negative for TB:	☐ No Follow-Up	☐ Re-Screen in One Year	
4b)	☐	Positive for Latent TB:	☐ HIV Test	☐ LTBI Treatment Onboard	☐ Repatriation
4c)	☒	Positive for Active~~Open~~ TB:	☐ Isolation	☐ Barrier Nursing	
			☐ Contact Tracing	☐ Refer Ashore to Infectious Diseases Unit	

Date of TB Screening Completion: _____ (e.g. 01-Apr-2016)

Name of Doctor: _____

Signature of Doctor: _____