STATUS REVIEW OF KNOWN TUBERCULIN REACTORS

Essentially repeated chest x-ray of asymptomatic tuberculin reactors, whether or not they have completed preventive therapy, is no longer recommended. (HHS Publication (FDA) 83-8204).

Independent Contractor Name: _____

Please check YES or NO in response to the following questions:

1. Are you a recent contact to an infectious case of tuberculosis?	☐ Yes	☐ No
2. Have you ever had an organ transplant?	☐ Yes	☐ No
3. Are you a recent (Within the last 5 years) immigrant from a country with a high rate of TB? If yes, what country?	☐ Yes	☐ No
4. Have you ever injected drugs?	☐ Yes	☐ No
5. Have you been in jail, prison, or a nursing home?	☐ Yes	☐ No
6. Have you ever worked in a lab that processed TB specimens?	☐ Yes	☐ No
7. Do you have any of the following medical conditions?		
a. Diabetes	☐ Yes	☐ No
b. Chronic kidney failure with dialysis	☐ Yes	☐ No
c. Leukemia	☐ Yes	☐ No
d. Lymphoma	☐ Yes	☐ No
e. Cancer of the head, neck, or lung	☐ Yes	☐ No
f. Stomach surgery	☐ Yes	☐ No
g. Immune problems (Diagnosed with HIV disease or taken Prednisone longer than one month)	☐ Yes	☐ No
8. Have you ever been told you have an abnormal chest x-ray?	☐ Yes	☐ No
9. Have you had any of the following symptoms recently?		
a. Cough and/or hoarseness lasting more than 3 weeks	☐ Yes	☐ No
b. Recent unexplained weight loss	☐ Yes	☐ No
c. Fever or night sweats for more than a week	☐ Yes	☐ No
d. A productive cough or coughed up blood		

If you answered NO to all of these questions, you do not fall into one of the groups that should receive a skin test. This determination is based on current standards provided to the Florida Department of Health and the Centers for Disease Control and Prevention, an agency of the U.S. Government, and endorsed by the American Lung Association of Florida. If you answered YES to any of these questions, you will be further evaluated by a Nurse and/or a Physician.

Signature: _____ Date: _____
Independent Contractor

Reviewed by:

Human Resources - Signature: _____ Date: _____

Staff RN - Signature: _____ Date: _____