Resource Family Approval (RFA)

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE for

Krista Foster Homes
County or Agency

Instructions: To be completed by each adult residing in an Resource Family home and reviewed and signed by a licensed health professional.

Patient Name: _____ Date of birth: _____ ☐ Male ☐ Female

Address: _____
Street Apartment # City Zip code

Telephone: _____
Home Work Cell

Country of birth: _____ Race/Ethnicity: _____ US arrival date (if applicable): _____

Travel outside the United States in the last 2 years: ..... ☐ **Yes** ☐ **No** If yes list country_____
Visitors from outside the United States in the last 2 years:..... ☐ **Yes** ☐ **No** If yes, list country_____

Please check one answer or fill in the blank:

1. Have you ever had a Bacille Calmette-Guérin (BCG) vaccine for tuberculosis (TB) disease?..... ☐ **Yes** ☐ **No** ☐ **Unknown**
   a. BCG dates: _____
2. Have you ever had a TB skin test?..... ☐ **Yes** ☐ **No** ☐ **Unknown**
   If YES, please provide:
   a. TB skin test date(s):_____
   b. TB skin test results..... ☐ **Negative** ☐ **Positive** ☐ **Unknown**
3. Have you ever been told that you had TB infection or disease? ..... ☐ **Yes** ☐ **No** ☐ **Unknown**
4. Did you ever take TB medication? ..... ☐ **Yes** ☐ **No** ☐ **Unknown**
   If YES, please provide:
   a. Name of the medication(s), number of pills and dates of treatment:
   _____
   b. Name of clinic where you were treated? _____
5. Do you currently have any of the following signs and symptoms of active TB disease?
   a. Persistent cough longer than two weeks duration..... ☐ **Yes** ☐ **No**
   b. Coughing up blood..... ☐ **Yes** ☐ **No**
   c. Hoarseness..... ☐ **Yes** ☐ **No**
   d. Fever..... ☐ **Yes** ☐ **No**
   e. Sweating at night..... ☐ **Yes** ☐ **No**
   f. Unexplained weight loss..... ☐ **Yes** ☐ **No**
   g. Unexplained excessive fatigue..... ☐ **Yes** ☐ **No**
   h. Other unusual symptoms:_____

6. Were you immunized **within the last 6 weeks** for measles, mumps or rubella? .....☐ **Yes** ☐ **No**

7. Are you undergoing any treatment, or do you currently have a medical condition, that could weaken your immune system? (Describe)_____

8. Do you have diabetes? …….....☐ **Yes** ☐ **No** ☐ **Unknown**
   If YES, please provide name of medication(s): _____

To be filled out by a licensed health professional:

9. Based on the information provided I determine the patient's risk of TB infection is …….....☐ **LOW** ☐ **HIGH**

   a. If HIGH, please list any follow up required: _____

FOR LICENSED HEALTH PROFESSIONAL ONLY	
DATE EXAMINED	SIGNATURE OF LICENSED HEALTH PROFESSIONAL
TELEPHONE NUMBER	PRINTED NAME OF LICENSED HEALTH PROFESSIONAL
ADDRESS OF LICENSED HEALTH PROFESSIONAL	