Department of Mental Health & Substance Abuse Services

Tuberculosis (TB) Symptom Screening Tool

Name (Last, First, MI): _____ **DOB:** _____/_____/_____

Facility: _____ **Contact Person:** _____

Address: _____ **Phone#:** _____ **Fax#:** _____

Program type: ☐ Residential ☐ Non-residential ☐ Personnel

INTERVIEWER INSTRUCTIONS: Check **YES** or **NO** for each item below.

Section I: Signs and Symptoms of TB Disease
Does the individual now have?

☐Yes	☐No	Cough lasting 3 weeks or longer?	☐Yes	☐No	Coughing up blood?
☐Yes	☐No	Chest pain?	☐Yes	☐No	Night sweats (drenching)?
☐Yes	☐No	Difficulty breathing?	☐Yes	☐No	Hoarseness and/or trouble swallowing?
☐Yes	☐No	Persistent fever and/or chills?	☐Yes	☐No	Persistent fatigue?
☐Yes	☐No	Persistent loss of appetite?	☐Yes	☐No	Other _____
☐Yes	☐No	Weight loss (without dieting)?			

Section II: Evaluation for TB Infection (TBI)
Has the individual had?

☐Yes ☐No Documented history of a previous **POSITIVE** TB test?
If **YES**, attach a copy of test results

☐Yes ☐No Documented history of previous **NEGATIVE** TB test in the past 12 months
If **YES**, attach copy of test results
If **NO**, refer for TB test

Section III: Disposition

Step 1 *Cough lasting 3 or more weeks plus any other symptom*	**Step 2** Evaluation for TB Infection (TBI)		**Step 3** **Action Needed:**	**Step 4** **Action Taken:** *(Check only one)*
	Documented previous *positive* test?	Documented *negative* test within last 12 months?		
YES	NA	NA	▪ **Notify physician immediately**	☐
NO	**YES**	NA	▪ Educate about TB ▪ If no Chest X-Ray (CXR) report, refer for CXR ▪ Recommend treatment for TBI if not previously completed	☐
NO	NO	**YES**	▪ Educate about TB	☐
NO	NO	NO	▪ Educate about TB ▪ Refer for TB test	☐

Action Taken: ☐No Action Required ☐Documentation Required ☐Refer to Health Dept for Testing
☐Referred to Healthcare Provider, if applicable: _____

Agency name: _____
Agency address: _____ Zip code: _____
Phone #: _____ Fax #: _____

_____ Date: _____/_____/_____
Interviewer Signature/Title