Tuberculosis Screening and Education

Tuberculosis Symptom Screen

Tuberculosis (TB) is caused by a bacterium called Mycobacterium tuberculosis. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. Not everyone infected with TB bacteria becomes sick. As a result, two TB-related conditions exist: latent TB infection (LTBI) and TB disease. If not treated properly, TB disease can be fatal. TB bacteria are spread through the air from one person to another. The TB bacteria are put into the air when a person with TB disease of the lungs or throat coughs, speaks, or sings. People nearby may breathe in these bacteria and become infected. TB is a treatable disease. If you have additional questions:

- Researchers contact ROHP at 617-358-7647
- All others contact OHC at 617-353-6630

SECTION 1. PERSONAL INFORMATION

Employee Name (Last, First, MI) **BU/BMC ID#** **Address**

Mobile Phone Number **Birth Date** **Position Title**

SECTION 2. Please complete the following questions by selecting the appropriate response or entering text in the field provided.

1. **Have you been at a temporary or permanent residence more than or equal to one month in a country with a high TB rate?** **YES** **NO**
   (Any country other than the United States, Canada, Australia, New Zealand, and those in Northern or Western Europe)
2. **What is your country of birth?**
3. **Do you have current or planned immunosuppression?** **YES** **NO**
   (Including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment recipient, treatment with a TNF-alpha antagonist (i.e., infliximab, etanercept, or other) chronic steroids (equivalent of prednisone greater than or equal to 15 mg/day for greater than or equal to 1 month) or other immunosuppressive medication)
4. **Have you been in close contact with someone who has had infectious TB disease since the last TB test?** **YES** **NO** **Don't Know**
5. **Have you been immunized with BCG (Bacille Calmette-Guerin) TB Vaccine?** **YES** **NO**
6. **I have had a past POSITIVE TB Test** **YES** **NO**
   (If yes to # 6 above, complete sections a to f below. If no, proceed to question 7)
   - **a. What year did you have a POSITIVE TB test?**
   - **b. Have you been treated for Tuberculosis?** **YES** **NO**
   - **c. When and how long did you receive treatment for TB?**
   - **d. What medication did you take?**
   - **e. What is the date of your last x-ray?**
   - **f. Where was your last x-ray taken?**

SECTION 3.

Please provide documentation of any positive test, written chest x-ray results, counseling and/or treatment if you have not already done so. Researchers should submit to ROHP@BU.EDU and all others to BUOHC@BU.EDU.

I am currently having symptoms of :

7. **Coughing lasting more than 3 weeks** **YES** **NO**
8. **Cough or spitting up any blood** **YES** **NO**
9. **Any unexplained weight loss** **YES** **NO**
10. **Drenching night sweats or fever lasting longer than 3 weeks** **YES** **NO**
11. **Any loss of appetite for longer than 2 weeks** **YES** **NO**
12. **Prolonged fatigue lasting more than 3 weeks** **YES** **NO**
13. **Chest pain** **YES** **NO**

Tuberculosis review of symptoms is part of the screening process. This is required by Centers for Disease Control and all Departments of Public Health.

By submitting this form, I confirm the answers are true and correct to the best of my knowledge and belief.

Signature **Date**