Last Name	First Name	MI
Patient Number		
Date of Birth (MM/DD/YYYY)	Month / Day / Year	
Race **Select from list**		
Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No ☐ Unknown		
Gender ☐ Female ☐ Male		
County of Residence **Select from list**		

N.C. Department of Health and Human Services
Division of Public Health
Epidemiology Section • TB Control

Record of Tuberculosis Screening

Section A.

Answer the following questions.

Do you have:	**Descriptions**	**Yes or No**
1. Unexplained productive cough	*Cough greater than 3 weeks in duration*	**Select**
2. Unexplained fever	*Persistent temp elevations greater than one month*	**Select**
3. Night sweats	*Persistent sweating that leaves sheets and bedclothes wet*	**Select**
4. Shortness of breath/Chest pain	*Presently having shortness of breath or chest pain*	**Select**
5. Unexplained weight loss/appetite loss	*Loss of appetite with unexplained weight loss*	**Select**
6. Unexplained fatigue	*Very tired for no reason*	**Select**

The above health statement is accurate to the best of my knowledge. I will see my doctor and/or the health department if my health status changes.

_____ _____/ ____/_____ _____
Signature *Date* *Witness*

Section B.

This is to certify that the above-named person (a) had a tuberculin skin test or an interferon gamma release assay (IGRA) on _____/_____/_____which was read as _____mm., which was interpreted as positive and (b) had a chest X-ray done on _____/_____/_____which showed no sign of active inflammatory disease.
(c) This person has no symptoms suggestive of active tuberculosis disease. A chest X-ray for tuberculosis is not indicated.

_____ _____ /_____ /_____
Licensed Medical Professional *Date*

Purpose: To be used for persons who:

(1) have had a significant reaction to the tuberculin skin test;
(2) have had a negative chest X-ray; and
(3) need a record of their tuberculosis status.

Preparation: To be completed by a licensed medical professional.

Section A: Record the person's answers to questions 1-6.

(1) If all answers are ***no***, have person sign where specified and continue to Section B.
(2) If any two answers are ***yes***, **do not** complete the record. Refer person for evaluation as appropriate.

Section B: Complete information as specified.

NOTE: Document this visit in person's clinical record and specify outcome, i.e., indicate that the record or a referral was given to the person.

Disposition:
(1) If all answers in Section ***A*** are ***no***, no copy required. Document as noted above.
(2) If any two answers in Section ***A*** are ***yes***, retain original and any further referral form in record. Destroy in accordance with Standard 5, *Records Disposition Schedule*, published by the N.C. Division of Archives and History.

Additional forms may be downloaded from the N.C. TB Control website:
https://epi.dph.ncdhhs.gov/cd/tb/docs/dhhs_3405_2017.pdf