

**TRINITAS SCHOOL OF NURSING
TB ASSESSMENT QUESTIONNAIRE**

Student's Name: _____ Course: _____

PLEASE COMPLETE AND RETURN TO DIRECTOR OF STUDENT HEALTH PRIOR TO REGISTRATION.

Your health record indicates that you are not a candidate for tuberculosis assessment with TB skin testing. The following questions will assist in determining if you need further evaluation for tuberculosis disease.

Do you have?

1. Weakened immune system caused by radiation, chemotherapy, HIV infection, chronic illness, steroid medication?
 No Yes- it is not required to divulge your diagnosis.

2. Persistent cough?
 No Yes- explain _____

3. Fever and/or night sweats?
 No Yes- explain _____

4. Unexplained weight loss?
 No Yes- explain _____

5. Feeling ill/tired/weak?
 No Yes-explain _____

6. Chest pain or coughing up blood?
 No Yes-explain _____

Student's Signature: _____ Date: _____

TO BE COMPLETED BY DIRECTOR OF STUDENT HEALTH FOR "YES" RESPONSES:

Appointment scheduled Yes No _____

MD Evaluation Yes No _____

Refer to follow-up Yes No _____

Signature of Director of Student Health: _____ Date: _____