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:_____

Adapted from TRMC Health form: 8/13