1. Last Name	First Name							MI		
2. Patient Number										
3. Date of Birth (MM/DD/YYYY)	Month		Day		Year					
4. Race ☐ 1. American Indian/Alaska Native ☐ 2. Asian ☐ 3. Black/African American ☐ 4. Native Hawaiian/ Other Pacific Islander ☐ 5. White ☐ 6. Unknown										
Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No ☐ Unknown										
5. Gender ☐ 1. Female ☐ 2. Male										
6. County of Residence										

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

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: http://epi.publichealth.nc.gov/cd/tb/docs/dhhs_3405.pdf.