WINONA STATE UNIVERSITY
Department of Graduate Nursing

Serial TB Screening Tool for Health Care Personnel (HCPs)

Date form completed: _____

Name: _____

Symptoms of active TB disease

(check all that are present)

☐ Coughing (> 3 weeks)

☐ Chest pain

☐ Fatigue

☐ Night sweats

☐ Coughing up blood

☐ Weight loss/poor appetite

☐ Fever/chills

Note: If TB symptoms are present, contact your health care provider for a chest X-ray and medical evaluation. Do not wait for the TST or TB blood test result.

HCP's TB history

Ever had a positive reaction to a TB skin test or TB blood test?

☐Yes ☐No

If yes: Date_____
Number of millimeters of induration: _____mm

Had a TB skin test in the past 12 months?

☐Yes ☐No

If yes: Date_____
Number of millimeters of induration _____ mm
Result_____

Treated for latent TB infection? ☐Yes ☐No Comments: _____

Treated for active TB disease? ☐Yes ☐No Comments: _____