ACTIVE TUBERCULOSIS (TB) DISEASE SCREENING FOR STAFF AND VOLUNTEERS IN LONG TERM CARE HOMES AND RETIREMENT HOMES

Name of Staff/Volunteer: _____ Date of Birth: _____

Please answer Yes or No to the following list of symptoms of active TB disease. If you have any of the symptoms below, you must be assessed by a healthcare provider prior to your placement at the facility.

SYMPTOM	YES	NO	DATE STARTED	COMMENTS
Current cough of more than 2 weeks duration	☐	☐		
Diagnosed with pneumonia but after 2 courses of antibiotics there is no improvement	☐	☐		
Coughing up blood	☐	☐		
Chest pain	☐	☐		
Shortness of breath	☐	☐		
Fever	☐	☐		
Night sweats	☐	☐		
Unintentional weight loss	☐	☐		
Fatigue	☐	☐		
Loss of appetite	☐	☐		

Checklist Completed By (Name): _____

Signature: _____ Date: _____

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If you require this information in an alternate format, please call 1 800 267-7120 and press 0.