Last Name	First Name	MI
Patient Number		
Date of Birth	Month / Day / Year	
Race		
Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No ☐ Unknown		
Gender ☐ Female ☐ Male		
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 or No**
1. Unexplained productive cough	*Cough greater than 3 weeks in duration*	
2. Unexplained fever	*Persistent temperature 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 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:
https://epi.dph.ncdhhs.gov/cd/tb/docs/dhhs_3405_2017.pdf