Queensland Government

TUBERCULOSIS CONTROL

Healthcare Worker / Student TB Assessment and Screening

Facility name: ……

URN:
Family name:
Given names:
Address:
Phone no:
Date of birth: Sex: M ☐ F ☐

To assist with assessing the need for TB screening, please complete questions 1–9. If you would like to be screened for TB, please also complete questions 10 and 11, and notify your Staff Health Nurse (if a health care worker) who will arrange testing. Students, please liaise with your University Administrator for screening processes. Please bring this form with you when you are tested.

1. Were you born in Australia?	Yes ☐	No ☐
If no, in what country were you born?		
What year did you arrive in Australia?		
2. Have you visited and/or lived in other countries for 3 months or more within the last 3 years?	Yes ☐	No ☐
Please provide country/ies:		
3. Have you ever been diagnosed with TB?	Yes ☐	No ☐
If Yes, what date did you complete treatment? / / Duration of treatment …… months		
Name of health provider: Where:		
Treatment prescribed:		
4. Have you ever been in contact with a person with active TB disease?	Yes ☐	No ☐
If yes, when/where?		
5. Have you ever been screened for TB i.e. Chest x-ray, Tuberculin Skin Test (Mantoux) and/or IGRAs (QuantiFERON Gold Assay)?	Yes ☐	No ☐
If yes, please provide date: / / Where: Results:		
Date: / / Where: Results:		
6. Have you ever had a BCG vaccination?	Yes ☐	No ☐
If yes, date: / / Clinic:		
7. Have you previously worked in any of the following settings?		
7.1. Respiratory units, infectious disease units or other medical units caring for TB patients	Yes ☐	No ☐
7.2. Clinical procedures units designed for investigation and have a high risk of transmitting suspected or unsuspected TB i.e. bronchoscopy, sputum induction, BCG bladder installations /immunotherapy	Yes ☐	No ☐
7.3. Microbiology and/other laboratories that handle specimens which may contain mycobacteria	Yes ☐	No ☐
7.4. Mortuaries	Yes ☐	No ☐
8. Will you be working in any of the above areas of your current health care setting? (Students, please see Screening Notes on next page)	Yes ☐	No ☐
9. Do you have any of the following symptoms?		
9.1. Cough of >2 weeks	Yes ☐	No ☐
9.2. Fevers	Yes ☐	No ☐
9.3. Recent unexplained weight loss	Yes ☐	No ☐
9.4. Haemoptysis (blood in sputum)	Yes ☐	No ☐
9.5. Night sweats	Yes ☐	No ☐
9.6. If yes to any, please describe:		

Queensland Government

TUBERCULOSIS CONTROL

Healthcare Worker / Student TB Assessment and Screening

Facility name:.....

URN:
Family name:
Given names:
Address:
Phone no:
Date of birth: Sex: M ☐ F ☐

ACTION REQUIRED: TB screening is offered to students and healthcare workers (HCW) in Queensland and is consent-based. Any student/HCW regardless of response is welcome to have TB screening. However, this assessment is used to determine risk and all students/HCWs are encouraged to present for TB screening based on the algorithm below.

Screening Notes

Tuberculin Skin Test (TST) (Mantoux) **Screening:** Offer to students or health care workers who give **any** of the following answers:

- Question 1 or 2: Africa, Asia, South America, Oceania & Pacific Islands (excluding Australia & New Zealand) and the former Soviet Union where previous TST <10mm

Offer to all students or health care workers who answer **Yes** to any of the following:

- Questions 4, 7, 8*, 9, provided the previous TST result (as per question 5) was <10mm

*If you are a Student and you do not know where your clinical placement will be, please disregard question 8. If you are then offered employment in one of the settings in question 7 and have not been screened for TB, please contact your nearest TB Control Unit.

Chest x-ray (CXR) and/or clinical assessment: Offer to students or health care workers who give **any** of the following answers:

- Question 1 or 2: Africa, Asia, South America, Oceania & Pacific Islands (excluding Australia & New Zealand) and the former Soviet Union where previous TST ≥10mm

Offer to all students and health care workers who answer **Yes** to any of the following:

- Questions 3
- Questions 4, 7, 8* or 9 where previous TST ≥10mm
- To those who re-present to an occupational health setting with symptoms after initial assessment

*If you are a Student and you do not know where your clinical placement will be, please disregard question 8. If you are then offered employment in one of the settings in question 7 and have not been screened for TB, please contact your nearest TB Control Unit.

OUTCOME:

□ **Nil screening required**

□ **Screening required**: □ TST: Appointment _____ □ CXR: Appointment _____

□ **Screening required but declined:**

- I have read and understood the recommendations for the assessment and screening process for tuberculosis.
- I decline to participate in the screening process for tuberculosis and am aware of the potential risks.

Student/HCW name _____ **Signature** _____
Date ____/___/___

Assessment clinician _____
Signature _____ **Date** ___/___/___

Queensland Government

TUBERCULOSIS CONTROL

Healthcare Worker / Student TB Assessment and Screening

Facility name:.....

URN:
Family name:
Given names:
Address:
Phone no:
Date of birth: Sex: M ☐ F ☐

10. What is your current occupation?

☐ Student HCW ☐ Medical officer ☐ Nurse ☐ Dentist/dental worker
☐ Speech therapist ☐ Radiographer ☐ Pharmacist ☐ Occupational therapist
☐ Physiotherapist ☐ Audiologist ☐ Laboratory worker ☐ Mortuary attendant
☐ Other: _____

11. Medical history

11.1. Have you had a recent viral illness?	Yes ☐	No ☐
If yes, describe:		
11.2. Have you had any vaccination within the last four weeks?	Yes ☐	No ☐
11.3. Do you have any medical conditions?	Yes ☐	No ☐
11.4. Are you currently taking any medications?	Yes ☐	No ☐
11.5. Do you have any allergies?	Yes ☐	No ☐

Tuberculin Skin Test (Mantoux) CONSENT

- I have received information about Tuberculosis (TB) and the tuberculin skin test (Mantoux) in a language which I understand.
- An interpreter service/cultural support person was provided as requested by me.
- I was given the opportunity to ask questions about the tuberculin test. Any questions asked have been answered to my satisfaction.
- I have responded to questions in the tuberculin skin test (Mantoux) fact sheet and I understand the details of the tuberculin skin test.

I, (please print):_____ **consent to the administration of the tuberculin test/s.**

Signature: _____ Date: _____/_____/_____

To be completed by an accredited TST/BCG provider

BCG history: ☐ Yes ___/___/___ ☐ No ☐ Unknown Mantoux consent signed: ☐ Yes
BCG scar: ☐ Present ☐ Absent BCG consent signed: ☐ Yes

	L/Human Initial test	Retest	BCG if required
Administration date			
Batch no.			
Dose			
Name and signature			
Venue where given			
Reading date	mm	mm	**Chest X-ray:** Date:____/____/____ ☐ Normal result ☐ Abnormal result ☐ TB related changes Action required:
Result			
Name and signature			
Venue where read			