



— TB SCREEN/INFORMATION/TESTING —

This agency strives to protect its staff and patients from tuberculosis through education, screening, testing and, when appropriate, referral for TB testing and treatment. At the same time, staff and patient confidentiality and rights will be protected in accordance with 42 CFR, Part 2 and the Health Care Information Access and Disclosure Act.

Chemically-dependent individuals are at a disproportionately high risk of contracted TB infection and developing active TB disease. The high incidence of HIV/AIDS among chemically-dependent persons further elevates this risk. Incidents of TB disease have been reported in chemical dependency programs. Therefore, for your protection and to deal with this serious public health problem, all staff members at this agency are tested for exposure to TB at least annually and all patients must have a TB test result in their patient treatment file. If you are positive for TB, you will be allowed to enter treatment only upon a written document stating that you are receiving medical treatment for TB and that you remain under the care of a doctor and are in compliance with your TB treatment program.

1. Have you experienced any of the following symptoms:

- Drenching night sweats of more than two weeks duration? Yes No
- Unexplained weight loss? Yes No
- Loss of appetite? Yes No
- Cough lasting more than two weeks and/or spitting up blood? Yes No
- Hoarseness and chest pain? Yes No

2. Do you have proof of a PPD skin test for TB given within the last calendar year? Yes No

3. If the PPD skin test for TB was positive, did you have a chest X-Ray taken within the last calendar year? Yes No NA

4. I refuse to take a TB test at this time. If you refuse, check "Yes" and initial. Yes _____ Initials No

You are required by the Washington State Department of Health to obtain a TB test. This can be done at any health department or your personal physician. Verification of test results need to be returned to us within ten (10) days of your signature today. Failure to do this will result in non-compliance with your treatment program.

I have read and understand the above precautions and agree to abide by these health rules.

Patient Signature _____ Date _____

Witness _____ Date _____

Patient Name (Print) _____