ANNUAL STATEMENT FOR TUBERCULIN REACTORS

NAME: _____

DATE OF BIRTH: _____

SIGNS/SYMPTOMS SCREENING (Yes/No):

_____ Cough lasting longer than three (3) weeks
_____ Unexplained fever
_____ Night sweats
_____ Unexplained weight loss
_____ Coughing up blood
_____ Chest pain

IF NONE OF THESE SYMPTOMS ARE PRESENT, A CHEST X-RAY IS NOT NECESSARY.

_____ _____
Nurse/Physician Date

[ ] I am tuberculin positive with negative CXR. I have had the recommended course of treatment for **Latent Tuberculosis Infection** (LTBI).

[ ] I am tuberculin positive. I have completed the recommended course of treatment for **Tuberculosis Disease**.

[ ] I am tuberculin positive and have not completed the recommended course of treatment.

If I develop any of the above symptoms, I agree to seek immediate medical attention.

_____ _____
Patient Date

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