☐ TB Contact Investigation CHART #: _____ DSW#: _____ UCSF#: _____ Surveillance Form - Revised 05/14/2019

ZUCKERBERG SAN FRANCISCO GENERAL TB SURVEILLANCE FORM

PLEASE COMPLETE ALL HIGHLIGHTED **AREAS**

Instructions *Tuberculin skin tests (TST) must be read within 48-72 hours.* **PLEASE WRITE LEGIBLY.**

Name: *Last:* _____ *First:* _____ M.I. ____ Employer: ○ UCSF ○ ZFGH ○ Other

Today's Date: ___/___/___ **Date of Birth:** ___/___/___ **Gender:** ○ Male ○ Trans Female ○ Female ○ Trans Male ○ Genderqueer

○ Gender Non-Binary ○ Not Listed ○ Decline to state. What was your sex assigned at birth? ○ Male ○ Female ○ Declined/Not Stated

SS#: XXX-XX- _____ **Work Title:** _____ Job **Class#:** _____ Supervisor's Name: _____

Department: _____ Location: _____ **Work Phone#:** _____

Home Address: _____ **Home/Cell Phone:** _____

City: _____ **State:** _____ **Zip:** _____

I. In the past year, did you have any of the following symptoms **for more than three weeks at any one time?**

	Yes	No
❶ Drenching night sweats	☐	☐
❷ Persistent fever	☐	☐
❸ Unexplained fatigue	☐	☐
❹ Unexplained weight loss	☐	☐
❺ Unexplained loss of appetite	☐	☐
❻ Swollen glands	☐	☐
❼ Shortness of breath	☐	☐
❽ Persistent coughing	☐	☐
❾ Coughing up blood	☐	☐
❿ Hoarseness	☐	☐

II. Has a healthcare provider told you that your immune system has difficulty fighting infection? Some possible causes of this includes medicine that lower immunity (prednisone, other steroids, anti-rejection drugs, chemotherapy, cancer, radiation therapy, HIV, etc ...), and organ transplants. Yes ☐ No ☐

III. Have you had any of the following?

	Yes	No
• Is this your **FIRST** TB skin test?	☐	☐
• Previous skin reaction to a TB skin test?	☐	☐
• Previous positive TB skin test?	☐	☐
• History of active TB?	☐	☐
• History of treatment for TB?	☐	☐

Employee/Volunteer Signature: _____ Questions? Call Employee Health at 206-3769

For MEDICAL STAFF to Complete

A positive TST is: ❶ ≥10 mm –*or*- ❷ ≥5 mm if person is a close contact to an active TB case, HIV-positive, or immunosuppressed (see # II above).

Clinician comments:

Clinician signature: _____ Date: _____ Specify: ☐1-step ☐2-step ☐Positive TST history

TST #1	PLACEMENT	READING
Date applied: _____	Site: ☐Right forearm ☐Left forearm Dose: 0.1cc ID	Date read: _____ Induration (mm): _____
Brand: ☐Tubersol ☐Other: _____	Lot #: _____ Exp. Date: _____	Designated reader (print name and title below):
Applied by (print name and title): _____		_____
Signature: _____		Signature: _____
Unit/Department: _____		Unit/Department: _____

TST #2	PLACEMENT	READING
Date applied: _____	Site: ☐Right forearm ☐Left forearm Dose: 0.1cc ID	Date read: _____ Induration (mm): _____
Brand: ☐Tubersol ☐Other: _____	Lot #: _____ Exp. Date: _____	Designated reader (print name and title below):
Applied by (print name and title): _____		_____
Signature: _____		Signature: _____
Unit/Department: _____		Unit/Department: _____