EMPLOYEE MANTOUX or Quanti*FERON* TEST RECORD

MEMO: All employees with potential exposure to patients with active infectious TB will be given the recommended mantoux test upon employment or at the time this policy is implemented. Follow-up testing will be given according to the TB risk classification of the facility.

Employees Name: _____ SS# _____(optional)

Initial test* performed (date): _____

Brand: _____ Lot #: _____ Exp. Date: _____

Performed by: _____

Date read: _____ By: _____

Result: _____ mm of induration OR *QuantiFERON:* _____

Date of second test: _____ Lot#: _____ Exp. Date:

_____

Performed by: _____

Date read: _____ By: _____

Result: _____ mm of induration

Recommendations/Treatment:

_____

_____

Employee has received a copy of their result: Yes ____ No ____

Employees signature: _____

Follow up testing will be performed (check): (1) ____ every ____ months

(2) ____ upon exposure

Date:	By Who:	Date Read:	Result:
_____	_____	_____	_____
_____	_____	_____	_____

Comments on any of the above results:

_____

_____

* If there is any indication that the employee tested positive in past or received BCG in past 5 years, follow the recommendations given by the CDC and/or pharmaceutical company. If in doubt, a blood test, QuantiFERON-TB may be used in place of the Mantoux test to be safe.

TB POST- EXPOSURE MANAGEMENT RECORD

TB POST-EXPOSURE MANAGEMENT RECORD

The following employee was the subject of an exposure to a patient with active TB on (date) _____ and was examined and treated as follows:

Employee Name: _____ SS# _____(optional)

Health Care Provider: _____

Type of Incident (describe) _____

_____

Reason for Exposure: _____

_____

Source Patient Information:

_____ Source patient has active TB.

_____ Source patient is being treated for active TB.

_____ Source patient was identified with active TB after the exposure.

_____ Source patient is known to be infected TB and HIV positive.

Employee's last TB test was performed on _____ and result was _____

Employee was administered a TB test (following incident) on: _____

By who: _____ Test was read on: _____

By who: _____ Result was: _____

Follow up TB test was performed (recommended 12 weeks) on: _____

By who: _____ Test was read on: _____

By who: _____ Result was: _____

Results were reviewed with the employee on _____

Employee Signature _____ Date _____

Recommendations/Treatment (if necessary):

_____

_____

(continued next page)

Employee hereby acknowledges that follow up treatment has been recommended.

Employees Signature: _____ Date _____

If any job restrictions during treatment have been recommended, explain here:

_____

_____

Additional follow-up evaluations are to be performed by _____

at the following intervals:

Date:	Appointment kept:	Report received:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

NOTE: This record will be retained for length of employment PLUS 30 years.

The following remedial action was taken to minimize or eliminate the likelihood of this type of exposure in the future:

_____

_____

_____

_____

_____

_____

Person filling out this report: _____ Date: _____

EMPLOYEE HEALTH SCREEN

TUBERCULOSIS HEALTH QUESTIONNAIRE

The employee below was tested and reacted positive to the Mantoux test. It is important to be alert to symptoms of TB since the Mantoux test can not be used as an indicator if employee is exposed.

Employee Name:

_____

Date of Hire: _____ Date of initial Mantoux test: _____

Please indicate (check yes or no) if you are experiencing any of the following symptoms:

Symptom	Yes	No
Productive cough (>3 weeks)	☐	☐
Persistent unexplained cough	☐	☐
Coughing up blood	☐	☐
Persistent low grade fever	☐	☐
Night sweats	☐	☐
Loss of appetite	☐	☐
Feeling tired or weak all the time	☐	☐
Swollen glands in the neck	☐	☐
Recurrent kidney or bladder infections	☐	☐
Shortness of breath	☐	☐
Chest pain	☐	☐
Unexplained tiredness	☐	☐

Comments regarding the above answers:

_____

_____

_____

_____ _____

Employee Signature Date

RESPIRATOR USE AND MAINTENANCE

The manufacturer's information and instructions must be followed when using HEPA Filter Respirators. Disposable respirators and disposable filters may be used more than once if the manufacturer's information so advises. Disposable and reusable respirators must be discarded if::

1. The elastic straps become loose or loose elasticity
2. The filter is dirty, perforated or has become wet
3. the face seal has become dry or ridged

Date Used	Amount of Time used	Date cleaned, examined and stored	Fit Test Required? Comments?

* Respirators are not required to be on-site for minimal and very low classified facilities