

**TB INTAKE/EVALUATION (LTBI, Case and Class B)
Clark and Skamania Counties**

PPD

Applied	Read	Result	mm	Applied	Read	Result	mm
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TB HISTORY

Source Immigrant/Refugee Class A TB Class B TB Contact Suspect Other _____

Current TB meds No Yes Start Date _____ Meds _____

Prior TB meds No Yes Dates _____ Meds _____

Known TB exposure No Yes Date _____ Exposure _____

Country of Origin _____ DOE _____ Language _____

MEDICAL HISTORY

FURTHER EVALUATION

Medication Allergies? No
Current Medications? No
 Yes

No	Yes	Symptoms	Onset/Duration
<input type="checkbox"/>	<input type="checkbox"/>	Cough/Hemoptysis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fever	_____
<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	_____
<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	_____

Medical History **Dates**

<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Lung disease/surgery	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Vision/Hearing Prob	_____
<input type="checkbox"/>	<input type="checkbox"/>	Surgery	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pain	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other:	_____

Substance Abuse **Amount/duration**

<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	_____
<input type="checkbox"/>	<input type="checkbox"/>	ETOH	_____
<input type="checkbox"/>	<input type="checkbox"/>	IVDU	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____

FEMALES ONLY

LMP _____
BCM _____

Weight _____ lbs _____ Kg Height _____
Temp if c/o fever: _____

Current CXR, Date _____

CXR Waived. CXR within 2 months available for review.
If no radiology report accompanies film, send film to VanRad for a reading

Foreign film, date _____
 US film, date _____

CXR Ordered, date _____

CXR held due to: _____

Sputums Ordered X 3 _____ Not ordered

Other _____

Chemistry Panel Date _____
 Not ordered Normal Abnormal

HIV: Not ordered Negative Positive Pending

Date:	Provider:



343-NonDOH March 2011

For persons with disabilities, this document is available on request in other formats.
To submit a request, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

DOB _____ MR# _____
NAME _____

