Mount Desert Island Hospital
10 Wayman Lane Bar Harbor ME 04609 Phone 207-288-5081
Employee Health Office located at Cadillac Family Practice
322 Main Street Bar Harbor ME 04609 Phone 207-288-5119 Fax 207-288-8449

Baseline Tuberculosis (TB) Screening

MDIH/BBRV healthcare personnel (HCP) shall have Baseline Tuberculosis Screening and Testing upon hire (i.e. preplacement) as per MDIH Healthcare Personnel Immunization/Infectious Disease Screening Policy and CDC guidelines. Associated tests are per Employee Health standing orders for MDIH OM and BBRV OM Employees.

Name: _____Date of Birth: _____

Department/Supervisor: _____ Telephone#:_____

Baseline individual TB risk assessment

Individual risk assessment and symptom evaluation help guide decisions when interpreting TB test results.
HCP should be considered at increased risk for TB if any of the following three statements are marked "YES".

1) Born in or temporary or permanent residence of ≥ 1 month a country with a high TB rate ☐YES ☐NO
(Any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe)

2) Current or planned immunosuppression, ☐YES ☐NO
Including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with TNF-alpha antagonist (e.g.,infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication.

3) Close contact with someone who had infectious TB disease since the last TB test ☐YES ☐NO

TB Symptom Evaluation

Are you *currently* experiencing any of the following symptoms of active TB:

Night sweats	☐YES ☐NO	Persistent cough (bad cough lasting 3 weeks or longer)	☐YES ☐NO
Unusual weakness or fatigue	☐YES ☐NO	Coughing up blood or sputum (phlegm from deep in lungs)	☐YES ☐NO
Unexplained weight loss	☐YES ☐NO	Unexplained Fever	☐YES ☐NO
Loss of appetite	☐YES ☐NO		

TB Test (TB Blood Test or a 2 step TB Skin Test (PPD))

Answers to the following questions will determine what TB test(s) and/or additional evaluation is needed.

Do you have documentation of a Negative TB Skin Test (PPD) in the last 12 months? ☐YES ☐NO

Have you ever received BCG? (A vaccine some countries use for TB and a treatment for bladder cancer) ☐YES ☐NO

Have you ever had a positive TB skin test (PPD) or TB blood test? ☐YES ☐NO

If Yes, Date of prior positive TB test: (provide documentation) _____

Date & result of corresponding Chest X-Ray: (provide documentation) _____

Have you ever been treated for TB? (if YES, provide documentation) ☐YES ☐NO

Signature: _____ Date: _____

_____Employee Health or Designee only to write bellow this line_____

Plan for TB Test and/or Additional Evaluation for TB Disease

Reviewer's Name/Title:_ Date:

Reviewer's Signature: Date: