

**Tuberculosis Symptom Screening Questionnaire to be used  
During PPD (Purified Protein Derivative) Shortage**

The Centers for Disease Control and Prevention (CDC) has declared a shortage of PPD solution used for administering the TB Skin Test (TST). This form is to be used for persons who are required to have TB screening for employment, post-secondary educational institution admission, long term residential care admission, correctional facility intake, or fulfillment of other statute or regulation. *Part A should be completed by the person for whom the TB Skin Test is required. A healthcare professional must evaluate the answers and assign a recommendation from Part B.*

- **If testing is deferred, the healthcare provider must check with their PPD solution supplier regularly to determine if PPD is available, and recall all patients with deferred TSTs as soon as is practical.**
- **Prior to using the form, all responsible facilities (skilled nursing facilities, home health care etc.) should verify that the suggested process is acceptable to their regulatory authority.**

**PART A**

- |   |     |    |
|---|-----|----|
| 1. Have you experienced any of the following symptoms in the past year?                               |     |    |
| a.) A productive cough for more than 3 weeks?   | Yes | No |
| b.) Hemoptysis (coughing up blood)?   | Yes | No |
| c.) Unexplained weight loss?  | Yes | No |
| d.) Fever, Chills, or night sweats for no known reason?   | Yes | No |
| e.) Persistent shortness of breath?   | Yes | No |
| f.) Unexplained fatigue?  | Yes | No |
| g.) Chest Pain?   | Yes | No |
| <br>  |     |    |
| 2. Have you had contact with anyone with active tuberculosis disease in the past year?                | Yes | No |
| <br>  |     |    |
| 3) Do you have a medical condition, or are you taking medications, which suppress your immune system? | Yes | No |
| <br>  |     |    |
| 3. Why are you required to have a TB Skin Test?   |     |    |

**Please provide details to any question answered "Yes".**

*I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.*

Signature of person required to be tested	Printed Name	Date

**PART B**

Upon review of the responses to the questionnaire and discussion with the person for whom the tuberculosis evaluation is required, I recommend as follows:

\_\_\_\_\_ There is no indication this person has active tuberculosis at this time. Their TB Skin Test should be deferred until the National PPD shortage has ended. ***Interferon Gamma Release Assay (IGRA) TB Blood Test may be considered as an alternative, if practicable. (client is insured, or can afford out of pocket).***

\_\_\_\_\_ Further evaluation, including a TB Skin Test, Interferon Gamma Release Assay or other medical evaluation is indicated, and should be completed prior to work placement or admission to a facility.

Healthcare Professional Signature	Printed Name	Date

Agency/Practice Name	Contact Phone