AGENCY MANTOUX (TB) SYMPTOMS CHECK REPORT FORM

This Section to be completed by Employee:

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Name:		**Date of Birth:**
Address:		
Telephone:	**( )**	**Email:**

This Section to be completed by Physician or Provider:

***NOTE TO PHYSICIAN/PROVIDER:**
This individual is excluded from the Agency's mandatory annual Mantoux test due to a documented positive test in the past or reaction to the test. Therefore, he/she is required to obtain an annual TB symptoms exam to ensure he/she does not possess active tuberculosis. (DOH Guidelines are noted below.)

BI-ANNUAL TB SYMPTOMS CHECK

Date of Exam	No Symptoms Or Work Limitations	Shows Symptoms/Please Detail	Signature/Title (MD, NP, RN, LPN)

☐ This individual does not show symptoms of active tuberculosis. I do not have any recommendations for further testing at this time.

☐ *This individual shows symptoms indicating of suspected or active tuberculosis disease and is under my care. The individual will not be permitted to work until the Agency receives a note from me stating that the conditions outlined below have been met. Recommended course of action will include:

_____

Examiner (Print Name): (MD, NP, RN, LPN)

Address:

Date of Exam:

Telephone: ( )

***** Physicians are required to refer any individuals or applicants with a significant reaction and/or a test result interpreted to indicate possible tuberculosis infection to a health care provider knowledgeable in the diagnosis of tuberculosis for a formal diagnostic evaluation to exclude active pulmonary tuberculosis." A physician's statement regarding the above exclusion shall be acceptable so long as it includes a recommendation as to when testing would be appropriate at a designated time in the future and/or how the person should be evaluated for active tuberculosis and a preventative therapy assessment.

All individuals who have test results indicating suspected or confirmed active tuberculosis disease shall be excluded from the work environment until adequate treatment is instituted and any coughs are resolved and sputum specimens are negative on three (3) consecutive AFB smears and until such time that documentation is obtained from a physician indicating that the above conditions have been met. (The exclusion from work is not applicable for those individuals with confirmed or suspected tuberculosis disease in areas other than the lung or larynx who are otherwise healthy and undergoing treatment.)

Please return completed form to: Resource Center for Independent Living ♦ PO Box 210 ♦ Utica, NY 13503-0210
Attention: Human Resource Department, CONFIDENTIAL
Phone: (315)797-4642 ♦ Fax: 1(888) 959-4260 ♦ Email: hrmedical@rcil.com