UCONN

Office of Clinical Placement Coordination
ocpc.office.uconn.edu

↓↓↓ Annual TB Questionnaire – ONLY for history of TB and/or positive TB test ↓↓↓

This form is ***only*** to be completed by student and provider if student has a history of TB or if any current TB test (blood test or PPD) is positive. In addition to this questionnaire, student must submit most recent chest x-ray (dated within 12 months).

If student does not have a history of TB or a current positive TB test, completion and submission of this form will not lead to compliance. Please refer to checklist on page 1 of this packet and/or module 4 of the Compliance Overview Training Video Series for your program, available at http://ocpc.office.uconn.edu/students.

Student Questionnaire

Have you experienced any of the following symptoms in the past year? Please indicate yes or no for each item.

1.	Persistent productive cough?	☐ Yes	☐ No
2.	Coughing up blood?	☐ Yes	☐ No
3.	Chest pain?	☐ Yes	☐ No
4.	Shortness of breath / difficulty breathing?	☐ Yes	☐ No
5.	Unexplained fever lasting more than 3 days?	☐ Yes	☐ No
6.	Unexplained night sweats?	☐ Yes	☐ No
7.	Unexplained sudden weight loss?	☐ Yes	☐ No
8.	Unexplained fatigue / run down feeling?	☐ Yes	☐ No
9.	Unexplained swollen lymph nodes or masses in your armpit or neck area?	☐ Yes	☐ No

Student Attestation

The information presented above is true and accurate to the best of my knowledge.

Student Signature: ________________________ **Date:** ____/____/____

Student Name (printed): ____

Provider Attestation

Please select one:

☐ I certify that no treatment is currently recommended for this student.

☐ I certify this student is currently undergoing treatment for LTBI and that said treatment should be completed by _________ (specify date).

☐ I certify that this student has completed all recommended treatment.

Provider Signature: __________________________ **Date:** ____/____/____ **Phone:** _____________

Provider Name (printed): _________________________ **Address/Stamp:** _____________________________

Provider Type: ☐ MD ☐ DO ☐ APRN ☐ PA _____________________________

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