Catholic Health

CATHOLIC HEALTH

--- *Provider* Tuberculosis Screening & *Annual Health Assessment* ---

Provider Name (Please Print): ____

ANNUAL TUBERCULOSIS SCREENING: Please complete Item A or Item B below.

A. TUBERCULOSIS SCREENING TEST

1. In the past year, are you aware of being exposed to anyone with active Tuberculosis? ❑ Yes ❑ No

2. Have you been treated for active or latent Tuberculosis? ❑ Yes ❑ No
   a. If yes, when was it treated? ____________________
   b. If yes, where were you treated? ____________________

3. Have you had any of the following symptoms of Tuberculosis? ❑ Yes ❑ No
   - ❑ Unplanned weigh loss of more than 10 pounds?
   - ❑ New cough for more than three (3) weeks?
   - ❑ Blood in your sputum?
   - ❑ Night Sweats?
   - ❑ Unexplained Fevers?
   - ❑ Loss of appetite?
   - ❑ Unexplained hoarseness of voice?

If the answer to questions 1 and/or 2 or 3 is "yes", and/or any of the above symptoms are indicated, it will require further review by a Catholic Health Associate Health nurse to determine if a PPD is warranted.

Provider Signature: ____ **Date:** ________

B. PREVIOUSLY POSITIVE PPD

Because you have had a positive PPD, history of TB, it is important to know if you have experienced fever, weight loss, night sweats, bloody sputum, new hoarseness, loss of appetite or unexpected cough (dry/productive) lasting more than 3 weeks.

Have you had any of the symptoms list above? ❑ YES ❑ NO
If yes, please explain: ____

Provider Signature: ____ **Date:** ________

ANNUAL PROVIDER HEALTH ASSESSMENT STATEMENT:
I have determined, to the best of my knowledge, that the above-named provider is free from any health impairment which is of potential risk to patients or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the individuals behavior.

____ ________________________
[Signature of your Practitioner] *[Date]*
(Note: Providers Cannot Sign for Themselves)

____
[Typed or Printed Name of your Practitioner]

Please fax completed document to the Medical Staff Office of your
Primary CH Facility:

- **Mercy Hospital of Buffalo: (716) 828-3472**
- **Sisters of Charity Hospital/SJC: (716) 862-1871**
- **Kenmore Mercy Hospital: (716) 447-6340**
- **Mount St. Mary's Hospital: (716) 298-2001**

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