

CATHOLIC HEALTH
--- Provider Annual Health Assessment & Tuberculosis Screening---

Provider Name: _____

ANNUAL TUBERCULOSIS SCREENING: Please fill in most recent results for annual Tuberculosis screening test or reasons for exclusion (if applicable) in the tables below. Individuals with negative screening tests must repeat tuberculosis screening test annually.

NOTE: Pregnancy and/or breastfeeding does not exclude providers from PPD skin testing. History of BCG vaccination is not a contraindication to receiving the PPD skin test.

<u>TUBERCULOSIS SCREENING TEST</u>		
<u>Test Name</u> (Check one of the below options)	<u>Test Date</u> (mm/dd/yy)	<u>Test Result</u>
<input type="checkbox"/> Tuberculin Skin Test (PPD)		Induration: _____ mm <input type="checkbox"/> Negative Date Read: _____ Individuals with new Positive PPD <input type="checkbox"/> Positive *(Answer symptoms questions below) Chest X-Ray Date: _____ Result: _____
<input type="checkbox"/> QuantiFERON-Tb Gold (if obtained)		<input type="checkbox"/> Negative <input type="checkbox"/> Positive *(Answer symptoms question below)
<input type="checkbox"/> T-Spot (if obtained)		<input type="checkbox"/> Negative <input type="checkbox"/> Positive *(Answer symptoms question below)
*SYMPTOMS Have you had any of the following symptoms persisting for ≥ 3 weeks: cough, loss of appetite, unexplained weight loss, night sweats, bloody sputum, new hoarseness, or unexplained fever? <input type="checkbox"/> Yes <input type="checkbox"/> No		

<u>EXCLUSION FROM ANNUAL TUBERCULOSIS SCREENING TEST</u>		
<input type="checkbox"/> Excluded from annual Tuberculosis Testing	N/A	Reason for Exclusion: (Please check one and answer symptoms question below) <input type="checkbox"/> Significant prior adverse reaction to testing <input type="checkbox"/> Known prior positive test with negative workup for active Tuberculosis or previous completion of treatment for Tuberculosis
*SYMPTOMS Have you had any of the following symptoms persisting for ≥ 3 weeks: cough, loss of appetite, unexplained weight loss, night sweats, bloody sputum, new hoarseness, or unexplained fever? <input type="checkbox"/> Yes <input type="checkbox"/> No		

ANNUAL HEALTH ASSESSMENT STATEMENT:

I have determined, to the best of my knowledge, that the above-named practitioner 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: Applicants 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