CPNW
Clinical Placements Northwest

Clinical Placements Northwest
Tuberculosis Self-Screening

Name:	
Date:	
Date Of Birth:	
Education Program:	

The following screening is to identify and manage any active TB risk. Accurate assessment and completion contributes to a safe and healthy clinical environment.
Instructions:
1. **Carefully read and answer all questions.**
2. **Sign the form to attest to its accuracy.**
3. **Upload the fully completed and signed form to your CPNW account.**

In the past 12 months have you had any of the following:		
Symptoms	**Yes**	**No**
Use of current or planned immunosuppression medication		
Close contact with someone who has had infectious TB disease since the last TB test		
Coughing for more than 3 weeks		
Coughing up blood		
Hoarsness		
Chest pain		
Persistent fever		
Excessive sweating at night		
Excessive fatigue		
Loss of appetite		
Unexplained weight loss		
Have you been evaluated by your healthcare provider for any yes answer?		

Comments:

Possible Additional Steps: An individual is considered at increased risk for TB if any of the statements on the risk assessment are marked “Yes.” Share with your program coordinator for next steps and required documentation.

Please complete, sign, and return this form to the appropriate department.
I certify that the above information is accurate;

Signature: ______________________________ Date: ____________