**Pre-Consultation Questionnaire – TB Screening appointment**

*You may have been in contact with a case of TB at work and, as a precaution; we are recommending testing to make sure you do not have TB infection. Before doing so, we will need your consent and also information about their health in general and any symptoms that are linked to TB. We would be grateful if you would complete and bring it to the appointment scheduled for you to attend for screening*

Please read each question carefully and try to answer every section as far as possible. Questions should be answered by ticking boxes or writing in the spaces provided. Any personally identifiable information returned in this questionnaire will remain CONFIDENTIAL to occupational health and will be retained in your occupational health records.

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| **Section 1: Personal Details** | | | | | | |
| **Surname** | |  | First name (s) |  | | |
| **Maiden name / previous surname (s)** |  | | | **Date of birth** | |  |
| **Title e.g..Dr, Mr, Mrs, Miss, Ms** |  | | Gender (male / female) | | |  |
| **NHS Number if known** |  | | | | | |
| **Your home address:** | | | | | | |
| Postcode | | | | | | |
| **Email address** | |  | | | | |
| **Country of birth** | |  | | | | |
| **If not UK, date of entry to UK** | | **\_\_\_/\_\_\_/\_\_\_\_\_\_** (dd/mm/yyyy) | | | | |
| **In case we need to contact you, please give one or more phone numbers where we may contact you during the day:** | | | **Is this your home, mobile, or work number?** | **May we leave a message stating who we are?** | | |
| **No** | **Yes** | |
|  | | |  |  |  | |
|  | | |  |  |  | |
| ***Note: If you have provided a mobile telephone number, we will contact you via SMS text message to remind you of future OH appointments.*** | | | | | | |
| **Section 2: GP Details** | | | | | | |
| **GP Name** |  | | | | | |
| **GP address:** | | | | | | |
| Postcode | | | | | | |
| **Section 3: Job Details** | | | | | | |
| **Employer Name** | |  | | | | |
| **Job title** |  | | | | | |
| **Department** |  | | | | | |
| **Manager’s name** |  | | | | | |

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| **Section 4: Symptom questionnaire, immunisation details and health history** | | | | | | | | |
| **1. Do you currently have any of the following symptoms? Please tick** | | | | | | | | |
| Weight loss |  | Dry cough |  | Becoming short of breath | | | |  |
| Fever |  | Cough producing sputum |  | Swelling under arms or neck | | | |  |
| Night Sweats |  | Blood in your sputum |  | Other | | | |  |
| If other, please state symptoms: | | | | | | | | |
| **2. Have you had a BCG vaccination?**  If YES, date (or year) of vaccination **\_\_\_/\_\_\_/\_\_\_\_\_\_** (dd/mm/yyyy) | | | | | **Yes** | **No** | **Don’t know** | |
| **3. Have you had TB before?**  If NO, go to Q6. If YES, where did you have TB in your body?  Lungs  Other part  If other please specify: | | | | | **Yes** | **No** | **Don’t know** | |
| **4. If you had TB before, where were you treated?** | | | | | | | | |
| **5. If you were treated, how long were you on TB treatment?**  Up to 3 months Up to 6 months Up to 9 months Up to 12 months Over 12 months | | | | | | | | |
| **6. Have you ever been in close contact with anyone with TB?**  If YES, when (date or year) were you in contact with them? **\_\_\_/\_\_\_/\_\_\_\_\_\_**  If YES, where were you in contact with them? | | | | | **Yes** | **No** | **Don’t know** | |
| **7. Have you ever been tested for TB?**  If YES, where were you tested for TB?  If YES, what was the result of the test? | | | | | **Yes** | **No** | **Don’t know** | |

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| **8. Do you have any health problems?**  If YES, please give details: | **Yes** | **No** |
| **9. Are you currently taking any medication?**  If YES, please give details: | **Yes** | **No** |
| **9. For female staff only are you currently pregnant or were you pregnant during the period of possible exposure?**  If YES, please give details: | **Yes** | **No** |

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| **Declaration** | | | |
| **I declare that the information I have given is correct to the best of my knowledge.**  **I consent to an occupational health assessment and being contact screened for TB which involves a Chest X-ray and a Blood Test**    **I understand that the contents of this form are confidential to Occupational Health.** | | | |
| **Signature** |  | **Date** |  |
| **Print name** |  | | |

***Thank you for taking the time to fill in this form***

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| **For OH use only** | |
| **screening investigation and results** | |
| **Patient details** | |
| **First Name:** | **Last Name:** |
| **Date of Birth:** **\_\_\_/\_\_\_/\_\_\_\_\_\_** (dd/mm/yyyy) | Cohort number |
| **Date of Screen: \_\_\_/\_\_\_/\_\_\_\_\_\_** (dd/mm/yyyy) | MRN Number: |

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| **screening investigation and results** | | | | | | | | | |
| **Chest X ray** | | | | | | | | | |
| **Chest X-ray taken** | | | | | | | **Yes** | | **No** |
| **Chest X-ray results (interim):** | | | | | | | | | |
| Chest X-ray NAD  Chest X-ray suggestive of ‘old TB’ | | |  | | Chest X-ray consistent with TB  Chest X-ray abnormal (not TB) | | |  | |
| **IGRA** | | | | | | | | | |
| **Blood taken for Quantiferon test/ T Spot** | | | | | | | **Yes** | | **No** |
| Reactive Non-reactive Indeterminate | | | | | | | | | |
| **Symptoms** | | | | | | | | | |
| **Any TB symptoms?** | | | | | | | **Yes** | | **No** |
| If YES, give details: | | | | | | | | | |
| **Sputum** | | | | | | | | | |
| **Sputum samples requested?** | | | | | | | **Yes** | | **No** |
| If YES, give details: | | | | | | | | | |
| **Outcome of Screening** | | | | | | | | | |
| No evidence of latent / active TB - discharged  Consultant follow up required: Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Recall for further investigations: Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| **Comments** | | | | | | | | | |
| Signed | | |  | | | | | | |
| Date |  | | OHA/P Stamp | |  | | | | |