

NATIONWIDE CHILDREN'S HOSPITAL  
COLUMBUS OH  
MEDICAL STAFF OFFICE

ANNUAL MEDICAL STAFF TUBERCULOSIS SURVEILLANCE

PRINTED NAME: \_\_\_\_\_

SECTION/DEPARTMENT: \_\_\_\_\_

QUALITY ASSURANCE INFORMATION PROTECTED BY LAW ORC 2305.25, 2305.251, 2305.252

TYPE OR PRINT CLEARLY

PLEASE READ THE FOLLOWING QUESTIONNAIRE CAREFULLY AND COMPLETE THE FORM ACCORDINGLY. IF THE QUESTIONNAIRE IS NOT COMPLETED AS REQUIRED, IT WILL BE RETURNED TO YOU.

DIRECT ALL TUBERCULOSIS RELATED QUESTIONS TO:

JODI VINSEL, EPIDEMIOLOGY (722-4990) OR DENNIS CUNNINGHAM, MD (722-4404).

ALL MEMBERS OF NATIONWIDE CHILDREN'S HOSPITAL MEDICAL STAFF MUST ATTEST TO THEIR TUBERCULOSIS STATUS ANNUALLY BY COMPLETING SECTION I OR SECTION II AND SIGNING THE FOLLOWING QUESTIONNAIRE. INDIVIDUALS WITH A PREVIOUS NEGATIVE SKIN TEST RESULT MUST RECEIVE A PPD INTERMEDIATE MANTOUX - 5TU TEST. INDIVIDUALS WHO HAVE NOT BEEN TESTED IN THE LAST FIVE YEARS SHOULD RECEIVE TWO-STEP TESTING. ANY INDIVIDUAL DEMONSTRATING A NEW CONVERSION TO POSITIVE PPD STATUS MUST UNDERGO A CLINICAL EVALUATION AND CHEST X-RAY AND SECTION III MUST BE COMPLETED AND SIGNED BY YOUR PHYSICIAN.

**SECTION I.** PLEASE PROVIDE THE FOLLOWING INFORMATION, INCLUDING DATE AND NAME INDIVIDUAL/HOSPITAL/CLINIC/LAB, ETC., WHO ADMINISTERED AND READ THE TEST. IF YOU CONVERTED FROM A NEGATIVE TO A POSITIVE SKIN TEST SECTION III MUST BE COMPLETED. YOU MUST ALSO NOTIFY THE NATIONWIDE CHILDREN'S HOSPITAL EPIDEMIOLOGY DEPARTMENT AT 722-4990 OR DENNIS CUNNINGHAM, MD AT 722-4404.

Date of last TB skin test in right arm: \_\_\_\_\_ Administered By: \_\_\_\_\_ Date read: \_\_\_\_\_ Read by: \_\_\_\_\_  
(must be within the last 12 months)

Interpretation: ( ) Negative ( ) Positive If positive, what was induration/mm's: \_\_\_\_\_

**SECTION II.** IF YOU HAVE HAD A HISTORY OF POSITIVE PPD YOU MUST COMPLETE THIS SECTION. IF YOU ANSWER YES TO ANY OF THE QUESTIONS IN II(B) AND NO TO II(C) BELOW, SECTION III MUST BE COMPLETED AND SIGNED BY YOUR PHYSICIAN.

- A. Have you knowingly had contact with a person whom had TB during the past year? ( ) Yes ( ) No
- B. Have you experienced any of the following symptoms during the past year?
- 1. persistent cough ( ) Yes ( ) No
  - 2. cough producing bloody sputum ( ) Yes ( ) No
  - 3. fever, chills ( ) Yes ( ) No
  - 4. night sweats ( ) Yes ( ) No
  - 5. prolonged fatigue ( ) Yes ( ) No
  - 6. unexplained loss of appetite/weight loss ( ) Yes ( ) No
- C. If you experienced any of the signs/symptoms listed above, was it determined that they were not related to active Tuberculosis? ( ) Yes ( ) No
- D. What was done to prove that these symptoms were not related to active tuberculosis?

IF ANY OF THE LISTED SIGNS OR SYMPTOMS OF TUBERCULOSIS OCCUR WITHIN THE NEXT TWELVE MONTHS, A PHYSICIAN MUST EVALUATE YOU.

► PRACTITIONER'S SIGNATURE

DATE

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**SECTION III.** IF YOU HAVE RECENTLY CONVERTED FROM A NEGATIVE TO A POSITIVE SKIN TEST OR IF YOU ANSWERED **YES** TO ANY QUESTIONS IN SECTION II (B) AND NO TO II(C) OF THIS QUESTIONNAIRE, THIS SECTION MUST BE COMPLETED AND SIGNED BY THE PHYSICIAN WHO TREATED YOU. THE PHYSICIAN MUST ATTEST TO ONE OF THE FOLLOWING STATEMENTS:

Date of last TB evaluation: \_\_\_\_\_

This individual has no evidence of active tuberculosis and is aware to report to the Nationwide Children's Hospital Department of Epidemiology, if any symptoms develop.

This individual has active tuberculosis and is being treated with appropriate therapy. This individual knows to notify Nationwide Children's Hospital Epidemiology Department.

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► TREATING PHYSICIAN'S SIGNATURE

DATE

Return this form to:  
Nationwide Children's Hospital  
Medical Staff Office  
Ross Hall 1<sup>st</sup> Floor  
700 Children's Drive  
Columbus OH 43205

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**SECTION IV. FOR MEDICAL STAFF OFFICE USE ONLY**

I have reviewed the requested information. The medical staff member has attested to his/her Tuberculosis status as requested. I recommend the following:

\_\_\_\_\_ No action

\_\_\_\_\_ Referral to Epidemiology for further evaluation

\_\_\_\_\_ Summary Suspension due to documented active Tuberculosis

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► Section/Department Chief's Signature

Date

RETURN FORM TO:  
NATIONWIDE CHILDREN'S HOSPITAL  
MEDICAL STAFF OFFICE  
ROSS HALL 1<sup>ST</sup> FLOOR  
700 CHILDREN'S DRIVE  
COLUMBUS OH 43205