Lutheran Family Health Centers/A Teaching Affiliate of Mount Sinai School of Medicine
Community Medicine Program
Tuberculosis Questionnaire (Form A, p. 1)
(To be used for initial evaluation of all clients and for periodic reevaluation of Tuberculosis Status)

I give permission to Lutheran Family Health Centers / Mount Sinai School of Medicine, Community Medicine Program to release to the Department of Homeless Services (DHS), Department of Health and Mental Hygiene (DOHMH), my case manager and the shelter director, the results of my TB evaluation as contained in the DHS/DOHMH Tuberculosis (TB) Screening Form.

I understand that my permission extends to disclosing DHS/DOHMH BTBC Form sections A, Client information and C, Assessment and Outcome to the DHS and DOHMH agencies and hereby authorize a medical representative to make the minimum disclosures from this form.

I understand that this permission is in accordance with New York State Law. Federal law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 and does not extend to the release of certain information, including HIV related, alcohol or drug treatment, and mental health treatment information contained within this form.[1]

I am entitled upon request and will receive documentation of the disclosures made from this form.

I understand that signing this release form is completely voluntary and my decision to sign or not sign this release will not effect my treatment or care.

____
Signature of client or legal authorized representative

____
Witness

[1] An AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA is needed in order to release any information pertaining to HIV, alcohol or drug treatment, and mental health treatment contained within this form.

Patient Information

Patient ID number (computer-generated): : ____________.

Last Name: ______________________________.

First Name: ______________________________.

DOB: ____/____/____.

Sex: M or F

Race:
(1) African American
(2) Hispanic
(3) White
(4) Other
(5) Asian
(6) Native American

HA#: __ __ __ __ __ __ __ __

I. Interview

1. Date: ____/____/____

2. Is this (choose one):
(1) Initial tuberculosis screening at this site?
(2) Rescreening?

3. Site: ______________________________

4. Interviewer initials: _____ _____ _____.

5. Age: ____ ____.

6. Total length of stay in the shelter system (months):
____ ____ ____. (see Table)

7. Reason for screening (**choose one** which best explains the reason for this evaluation):
(1) Work program physical
(2) Housing form physical
(3) Routine primary care
(4) Shelter staff recommendation
(5) Exposure to active tuberculosis
(6) Active tuberculosis diagnosed elsewhere
(7) A clinical picture consistent with active tuberculosis
(8) Active tuberculosis in past, not active now
(9) Drug or alcohol program physical exam
(10) Comprehensive Care Program routine screening
(11) Routine every six month TB evaluation
(12) Other, explain:

8. Prior tuberculin skin testing **(TST)** or Quantiferon Gold **(QG)** results **(choose one)**:
(1) None (never done)
(2) Documented TST(+)
(3) Documented TST(-)
(4) Undocumented TST(+)
(5) Undocumented TST(-)
(6) Unknown result (patient is uncertain)
(7) Documented QG(+)
(8) Documented QG(-)
(9) Undocumented QG(+)
(10) Undocumented QG(-)
(11) Unknown QG result (patient is uncertain)

9. Prior TST or QG test date: ____/____/____.

10. If TST(+) or QG(+) by history, did the patient receive INH or other LTBI therapy?

(1) Yes (2) No (3) Unknown (4) N/A

11. If the patient received INH or other LTBI therapy, how long was he/she treated (in months)?

____ ____ ____.

11a. What agent(s) were used (circle all that apply):
(1) INH (2) RIF (3) PZA (4) Rifabutin (5) Unknown

Active tuberculosis can cause symptoms that mimic other diseases. Several symptoms can be serious and should be evaluated by a physician if any of them are present. Patients not on TB treatment, but who should be must be evaluated by a physician as well. Ask the patient the following questions and if the answer to any is yes, (s)he should see a physician.

12. Do you now have a cough that has lasted for at least three weeks?

Yes ________ No ________

13. Do you now have fever/chills that have lasted for at least one week?

Yes ________ No ________

14. Do you now have drenching sweats during the night? (e.g., wanted to change clothing or sheets at night because they were very wet)

Yes ________ No ________

15. Have you lost more than 10 lbs. in the past two months?

Yes ________ No ________

16. Have you now or ever coughed up blood? (e.g., seen red blood in phlegm or mucus from the mouth)

Yes ________ No ________

17. Have you ever been treated or told you should be treated for TB?

Yes ________ No ________

18. Have you presently or have you ever been in close contact with person(s) known to have TB or who are on treatment for **ACTIVE TB?** (e.g., a family member, a shelter roommate, a close friend, anybody living in the same house or sleeping in the same room)

Yes ________ No ________