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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-01679 (12/2015) | **STATE OF WISCONSIN**Wis. Admin. Code § DHS 105.17(1r)(a-b) |
| **COMMUNICABLE DISEASE / TUBERCULOSIS SCREENING QUESTIONNAIRE** |
| The Department requires that health care agencies or providers screen all health care staff **WITHIN 90 DAYS BEFORE DIRECT CONTACT AND PERIODICALLY**, to ensure that staff is free of any communicable diseases before coming into contact with clients. This form is intended to provide guidance for providers. Use of this form is optional. |
| Name – Employee Completing Form      |
| **COMMUNICABLE DISEASE SCREENING** |
| Are you experiencing any of the following symptoms? |
| [ ]  Yes [ ]  No | 1. Sore throat
 |
| [ ]  Yes [ ]  No | 1. Rash / vesicles on skin
 |
| [ ]  Yes [ ]  No | 1. Cold sore
 |
| [ ]  Yes [ ]  No | 1. Fever and rash
 |
| [ ]  Yes [ ]  No | 1. Fever and respiratory symptoms – cough, runny nose
 |
| [ ]  Yes [ ]  No | 1. Drainage from eyes, ears
 |
| [ ]  Yes [ ]  No | 1. Skin lesion, cyst, boil
 |
| [ ]  Yes [ ]  No | 1. Nausea, vomiting
 |
| [ ]  Yes [ ]  No | 1. Diarrhea
 |
| [ ]  Yes [ ]  No | 1. Cough lasting more than three weeks
 |
| [ ]  Yes [ ]  No | 1. Swollen lymph nodes
 |
| [ ]  Yes [ ]  No | 1. Non healing wound
 |
| [ ]  Yes [ ]  No | 1. Returned from travel in another country within the last month
 |
| Have you ever been told by a physician or other health care provider that you have any of the following conditions? |
| [ ]  Yes [ ]  No | 1. Hepatitis A, B, or C
 |
| [ ]  Yes [ ]  No | 1. Tuberculosis
 |
| [ ]  Yes [ ]  No | 1. HIV / AIDS
 |
| **TUBERCULOSIS (TB) SCREENING** |
| Are you experiencing any of the following symptoms? |
| [ ]  Yes [ ]  No | 1. Persistent coughing
 |
| [ ]  Yes [ ]  No | 1. Coughing up bloody sputum or blood
 |
| [ ]  Yes [ ]  No | 1. Night sweats
 |
| [ ]  Yes [ ]  No | 1. Unexplained fatigue
 |
| [ ]  Yes [ ]  No | 1. Fever recurring
 |
| [ ]  Yes [ ]  No | 1. Unexplained weight loss
 |
| [ ]  Yes [ ]  No | 1. Positive for TB – either skin test or blood test
 |
| [ ]  Yes [ ]  No | 1. Have you ever been told by a health care provider that you have had active TB?
 |
| [ ]  Yes [ ]  No | 1. Have you ever cared for or lived with anyone diagnosed with active TB?
 |
| [ ]  Yes [ ]  No | 1. Have you worked or volunteered in a setting where TB may be more common, e.g., homeless shelter, nursing home, group home, prison?
 |
| Depending on the responses to the above questions, the registered nurse (RN) reviewing this document may refer you for a follow-up appointment with your physician, nurse practitioner (NP), or physician’s assistant (PA). At this appointment you will receive written documentation that you pose no risk for exposing others to communicable diseases. |
| **I acknowledge that the above information is true and correct to the best of my knowledge.** |
| **SIGNATURE** – Employee Completing Form | Date Signed (MM/dd/yyyy)      |
| **OFFICE** **USE** **ONLY** | **[ ]  Yes [ ]  No** I have conducted a screening and have reviewed the information on this form. The employee appears to be clinically free from communicable disease and TB.**[ ]  Yes [ ]  No** **RN referral to physician, NP, or PA** |
| **SIGNATURE** – RN Screener | Name – RN Screener (print)      | Date Signed (MM/dd/yyyy)       |