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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-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) |