# Appendix C.11 – Sample TB Test Form

**ABC Foster Grandparent/Senior Companion Program**

Address

Phone:

Email address (or fax number):

*[Note: TB Tests* ***are not*** *required byAmeriCorps Seniors but are required by some sponsoring agencies and volunteer stations.]*

**TB Test Form**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A TB test is required to participate in the ABC Foster Grandparent/Senior Companion Program.If the volunteer has had a positive TB test in the past, please skip this test and complete the next page.

PPD Test Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Read: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of mm induration: Results/Interpretation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROVIDER INFORMATION REQUIRED:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Health Professional Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hospital/Clinic/Organization Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date

**IF PREVIOUS POSITIVE RESULTS SKIP TEST AND GO TO THE NEXT PAGE**



**ABC Foster Grandparent/Senior Companion Program**

Address

Phone:

Email address (or fax number):

**Positive Tuberculosis (TB) Test Screening Form**

**Please fill out only if the volunteer has had a POSITIVE TB test in the past.**

Date of Positive Test Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was a chest X-ray done at that time: Yes No

 If yes, was it normal? Yes No

Did volunteer receive anti-TB medication? Yes No

 How long did they take it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last chest X-ray:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What was the result? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If **POSITIVE** within the last year has volunteer been treated for:

Unusual/persistent cough? Yes No

Coughing up blood? Yes No

Shortness of breath? Yes No

Persistent fever/chills? Yes No

Night sweats? Yes No

Unexplained weight loss? Yes No

Chronic fatigue? Yes No

Know~~n~~ TB exposure? Yes No

Comments and/or follow-up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Professional Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital/Clinic/Organization Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_