Complete Name and Signature of Health Staff:

TB SCREENING CHECKLIST

Jail/Prison:_____ Date:_____
Name: _____ Sex: _____ Age: ___
Complete Address:_____
Name of Contact Person: _____ Relationship: _____
Address of Contact Person:_____ Phone/Emai: _____

		No	Yes	
A.	Unexplained cough, any duration	☐	☐	
B.	Blood streaked sputum	☐	☐	
	Weight loss or BMI < 18.5	☐	☐	
	Persistent fever	☐	☐	
C.	BMI < 18.5	☐	☐	Weight:____ Height:____ BMI:___
	Known medical conditions	☐	☐	

(Clinical high-risk groups: HIV/AIDS, Diabetes, End-stage renal disease, Cancer, Connec tive tissue diseases, Autoimmune diseases, Scoliosis, Gastrectomy, Solid organtransplantation, Prolonged systemic steroids)

D. Chest x-ray suggestive of TB: ☐ ☐

E. History of previous TB treatment ☐ ☐ If outcome known, specify: _____

F. Exposure to TB case ☐ ☐ If known, specify: ☐ TB ☐ MDR-TB

Remarks: ☐ Presumptive TB
☐ Presumptive DR-TB
☐ No TB
☐ Ongoing TB treatment (Ask for NTP Referral Form)

Presumptive TB if:
Unexplained cough of any duration (A) with/without other signs/symptoms (B) or risk factors (C). X-ray suggestive of TB (D)
If with any signs/symptoms (B) or risk factors (C), refer to physician.
In absence of physician, you may consider as presumptive TB.

Presumptive DR-TB if:
Presumptive TB with previous treatment (E)
Presumptive TB with exposure to known active DR-TB case (F)