Appendix B: Active Tuberculosis (TB) Disease Screening for Staff and Volunteers in Long Term Care Homes and Retirement Homes

Name of Staff/Volunteer: _____ Date of birth: _____

Please answer Yes or No to the following list of symptoms of active TB disease. If you have any of the symptoms below, you must be assessed by a healthcare provider prior to your placement at the facility.

Symptom		Date Started YYYY-MM-DD	Comments
Current cough of more than 2 weeks duration	☐ YES ☐ NO		
Diagnosed with pneumonia but after 2 courses of antibiotics there is no improvement	☐ YES ☐ NO		
Coughing up blood	☐ YES ☐ NO		
Chest pain	☐ YES ☐ NO		
Shortness of breath	☐ YES ☐ NO		
Fever	☐ YES ☐ NO		
Night sweats	☐ YES ☐ NO		
Unintentional weight loss	☐ YES ☐ NO		
Fatigue	☐ YES ☐ NO		
Loss of appetite	☐ YES ☐ NO		

Checklist completed by: _____
NAME (PRINTED)

Signature: _____ Date: _____
YYYY-MM-DD

02-2023