



**For Occupational Health use only**

Surname: \_\_\_\_\_ First name: \_\_\_\_\_

**Initial assessment**

	Yes	No		Yes	No
Mantoux test required	<input type="checkbox"/>	<input type="checkbox"/>	To discuss with OHP	<input type="checkbox"/>	<input type="checkbox"/>
Quantiferon TB test (IGRA) required	<input type="checkbox"/>	<input type="checkbox"/>	OHP appt required	<input type="checkbox"/>	<input type="checkbox"/>
Chest X-ray required	<input type="checkbox"/>	<input type="checkbox"/>	Screening complete	<input type="checkbox"/>	<input type="checkbox"/>

OHA/OHCN/OHT signature: \_\_\_\_\_ Name stamp: \_\_\_\_\_

Date: \_\_\_\_\_

**Before repeat IGRA test**

Since your last IGRA test have you had:	Y	N	<i>If yes to any of the questions please give dates and details:</i>
<ul style="list-style-type: none"> <li>• a cough lasting for more than 3 weeks?</li> <li>• weight loss for no obvious reason?</li> <li>• a persistent fever?</li> <li>• heavy night sweats?</li> <li>• fatigue or a general or unusual sense of tiredness?</li> <li>• loss of appetite?</li> <li>• coughing up blood (haemoptysis)?</li> <li>• swollen glands or joints?</li> <li>• recurrent/persistent kidney/bladder infections?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	
Any current immunosuppressive medication/health condition?	<input type="checkbox"/>	<input type="checkbox"/>	
Any vaccinations within the last four weeks?	<input type="checkbox"/>	<input type="checkbox"/>	

Student/employee signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Student/employee signature: \_\_\_\_\_ Date: \_\_\_\_\_