



Name: _____ ART#: _____ Gender: M F Date of Birth: ___/___/___

Date of Screening	/ /	/ /	/ /	/ /	/ /	/ /
Age						
1. Is child currently receiving antiTB medications? (Yes or No) If Yes, STOP Screen. Rescreen after completion of TB Treatment. If No answer questions below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is child currently receiving Isoniazid Prophylactic Therapy (IPT)? (Yes or No)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. TB Exposure History: Close contact with a person diagnosed with pulmonary TB in the past 12 months? (Yes or No)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. TB Symptom Screen: Does the child currently have any of the following TB symptoms (Yes or No)						
A. Persistent, non remitting cough for > 2 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Documented weight loss or failure to thrive during the past 3 months, not responding to nutritional rehabilitation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Persistent fever > 2 weeks reported by parent	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Night sweats (regular sweating requiring a dry set of night clothes or change of bedding)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Screening Results: (A through D above) Positive = presence of one or more of symptoms Negative = absence of all symptoms	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
5. Follow-up						
A. Child has No Exposure to TB and TB Screen Negative: Re-screen in 6 months. Write date for next screen.	/ /	/ /	/ /	/ /	/ /	/ /
B. Child has Exposure to TB and /or Positive Symptom Screen : Complete first half of the National Tuberculosis Diagnostic Worksheet and send child for evaluation by MD. Indicate if child was evaluated by MD (Yes or No)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Nurse Initial/Signature						



Instructions

- **For New Forms:** Record the **Patient's Name, ART Number, Gender** and **Date of Birth** at the top of the form
- **For Previously Used Forms:** Review the notes about the previous visit screen before starting.
- **Screening Date:** Record the day (**DD**), month (**MM**), and year (**YY**) screening was performed.
- **Age:** Record the child's age.

1) Is child currently receiving anti TB medications ? Ask the caregiver if child is currently on antiTB treatment? (Yes) if yes stop screen. Rescreen after completion of antiTB treatment. (No) continue TB screen by asking questions below.

2) Is child currently on Isoniazid Prophylactic therapy (IPT)?

Yes (Y) or No (N). Children on IPT should be screened carefully for signs and symptoms of TB.

3) TB Exposure History : Ask the parent or caregiver if the child has been in close contact (living in the same household or in frequent contact) with any person who was diagnosed with pulmonary TB in the past 12 months. Write **(Yes)** if the child has a close contact with pulmonary TB and **(No)** if there is no history of TB contact.

4) TB Symptom Screen: Complete TB screening by asking the caregiver if the child **currently** has any of the TB symptoms. Write **(Yes)** or **(No)** in the appropriate column.

- A. Persistent cough for > 2 weeks?
- B. Documented weight loss or failure to thrive clear deviation from previous growth trajectory and/or documented crossing of percentile lines) during the past 3 months, not responding to nutritional rehabilitation. For growth assessment, please look at the growth chart to ascertain if there has been growth failure.
- C. Persistent fever >2 weeks reported by parents
- D. Night sweats (regular sweating that requires a dry set of night clothes or change of bedding).

TB Screening Outcome:

Presence of any symptom= **Positive.**

Absence of all symptoms= **Negative.**

Tick the appropriate box

5) Follow-up

A. Child has No Exposure to TB and symptom screen is negative:

Rescreen the child in 6 months. Record the date of the next screen in the space provided.

B. Child has Exposure to TB and/ or Positive TB Symptom Screen:

Complete first half of the National Tuberculosis Diagnostic Worksheet and send child for evaluation by MD. Indicate if child was evaluated by MD **(Yes or No)**

6) Nurse Initial/Signature