GQR Healthcare

TB SURVEILLANCE & HISTORY FOR INDIVIDUAL

Name: ______________________________________ Date: _________________

Date of Birth: _______________________________ Last 4 SSN: _____________

Please check if you have had any of the following:	Yes	No
Previous positive TB skin test **Date of past positive:** _________________________		
BCG Vaccine		

In the past 12 months have you had any of the following: ***If Yes please explain in Comment box below***		
Symptoms:	**Yes**	**No**
Coughing for more than 3 weeks		
Coughing up blood		
Hoarseness		
Chest pain		
Persistent Fever		
Excessive sweating at night		
Loss of appetite		
Unexplained weight loss		
***Comments:**		

I certify that I do NOT show signs of active TB disease.

Provider Name: ____

Signature: ____ Date: _______________

Please fax to: 209-391-1660 or email a copy to clinicalcredentialing@gqrgm.com.