Tuberculosis (TB) Test Notice

In accordance with The Home Care Services Consumer Protection Act, ALL Home Care Aides (HCA) are now mandated to have a copy of a TB test taken within the last two years, including the date of the most recent Tuberculosis examination, in their employee personnel files (Personnel Records).

For Home Care Aides submitting this information, the test must be taken within 30 days of receiving this notice. **Based on this requirement, completion of your TB test is an urgent matter to continue to provide respite care through the Regional Center.**

If you currently have your own medical insurance and/or doctor please feel free to set up an appointment through your own medical provider. If you do not have a medical provider, HGA has arranged for the following medical provider below to provide a TB test for you at the cost of **$25.00 (cash only).**

Dr. Peace
4326 Western Ave.
Los Angeles, CA 90062
(323) 299-9914
Contact: Yancy

If you would like to use our medical provider, you must contact their office directly to schedule an appointment. Appointments are available on Monday, Tuesday, and Wednesday afternoons. Once the exam is completed, please note that you will be required to return to the office 48 hours later to receive your results.

HGA has provided a form for your medical provider to use if requested. We will also accept TB test results from providers on their own letterhead with signature.

If you have any additional questions or concerns, please feel free to contact our office at the phone number provided below at your convenience.

Thank you,

Marc Adderly
Executive Director

*****If you have already provided HGA with TB Examination Documentation then please disregard this notice*****

Employee Tuberculosis (TB) Testing

Either the Two-Step TB Skin Test or an approved TB Screening Blood Test. If the second skin test or the single TB screening blood test is negative or if a documented history of negative TB screening test can be provided and the employee has no signs or symptoms of TB, a single "annual" TB Screening schedule can be maintained every year thereafter.

Name: ____ DOB: ________________________
(Please Print)

FIRST STEP of the TWO-STEP TST or ANNUAL SERIAL TB SKIN TEST (circle one)

Date Test Given: (mm/dd/yy); ______________________ Test Given By: ________________________

Site: ☐ Left Arm Measurement of Induration (millimeters): _______________________

☐ Right Arm

Date Test Read: ____________________________ Test Read By: ______________________________

Interpretation: ☐ Negative ☐ Positive

If a tuberculin skin test or the IGRA blood test is positive or a person exhibits signs and symptoms suspicious for tuberculous, a medical evaluation is required.

If a person has previously documented positive TB screening test or a documented diagnosis of TB or LTBI in the past, perform an annual risk assessment instead of the TST or IGRA. Repeat CXR is only required in new symptoms develop.

CHEST X-RAY (CXR)

Documentation that the CXR was performed to rule-out tuberculosis due to a positive TB skin test, IGRA blood test or the development of signs or symptoms of TB must be in the CXR report or comments.

Date of CXR (mm/dd/yy): _________________________________

Interpretation: Normal Abnormal

Comments:
____
____

____

____

For more information on TB Services and Testing: http://publichealth.lacounty.gov/tb/TBTesting.htm

Employee Tuberculosis Risk Assessment

Last Name: __________________ First Name: ______________ DOB: __________________ Age: _____

1. Has the employee received BCG vaccination?

☐ YES

☐ NO

Notes Related to Assessment:

____

____

2. Date of last TST: ________________ Results: ____

City & State: ___________________________ Based on Induration and History the TST is:

Documented: ☐ NO ☐ YES ☐ Negative ☐ Positive

3. Has the employee had a chest x-ray in the past?

☐ NO

☐ YES Year: ______ Where: _________________ Results: ____________ Reason: ____________

4. Has the employee lived or travelled outside of U.S.A within the last five (5) years?

☐ NO ☐ YES (If Yes – Where/When)____ _

5. Been in close contact with a person sick with TB?

☐ NO ☐ YES (If Yes – Who/When) ____

6. Has the employee ever been treated for TB?

☐ NO ☐ NOT SURE ☐ YES (ACTIVE TB) ☐ LTBI

Medications Taken: ____

Where: ___________________Year: ___________ Duration & Description of Tx: __________________

7. Does the employee have any of the following symptoms? ☐ NO ☐ YES

☐ Loss of Weight Usual Weight: _____________ lbs. Today's Weight: _____________________lbs.

☐ Cough ☐ Fevers ☐ Night Sweats ☐ Fatigue ☐ Loss of Appetite ☐ Other: ____________

Comments: ____

Note: If active TB is suspected do CXR

CXR Recommended ☐ NO ☐ YES Date: __________________ CXR Result: _____________________

Medication Recommended? ☐ NO ☐ YES Date: __________Medication Start Date: ____________

Reason Refused Rx: ☐ Personal Preference ☐ Previous Treatment ☐ TB Education/Literature

I, attest that the above information is true, to the best of my knowledge and consent to an annual TB evaluation; I shall comply with NAC 441A.375 (7) which provides the following:

A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis.

Employee Signature: ____ Date: ____________________

Authorized Assessor's Signature: ______________________________ Date: ____________________