



939 Old Ranch House Rd.
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OptimistPrimeCare Tuberculosis Screening Referral

Screening reason: ☐ New Hire ☐ Bi-Annual

Employee Name _____ Employee Phone: _____

Employee Birthdate: _____ TB assessment and/or examination date: _____

☐ Based on the TB test results, the patient is clear of active tuberculosis infection.

TB test type: ☐ Skin test ☐ Chest X-ray ☐ Blood test

☐ This employee has active tuberculosis and is ineligible for employment per Department of Social Services Home Care Consumer Protection Act (AB 1217).

Bi-Annual screening (only for employees with a positive TB test and a negative chest X-Ray)

Answer	Symptom	Onset and duration of symptom
<input type="checkbox"/> No <input type="checkbox"/> Yes	Cough for 3 or more weeks	
<input type="checkbox"/> No <input type="checkbox"/> Yes	Coughing up blood	
<input type="checkbox"/> No <input type="checkbox"/> Yes	Fever	
<input type="checkbox"/> No <input type="checkbox"/> Yes	Night sweats	
<input type="checkbox"/> No <input type="checkbox"/> Yes	Unexplained weight loss	Amount:
<input type="checkbox"/> No <input type="checkbox"/> Yes	Unusual weakness or fatigue	

☐ Based on the TB screening questionnaire, the patient is clear of active tuberculosis infection.

☐ This employee is subject to further screening and is currently ineligible until cleared by an authorized medical provider per Department of Social Services Home Care Consumer Protection Act (AB 1217).

Name and signature of Health Care Provider completing this risk assessment and/or examination:

Provider Name: _____ Signature: _____ Date: _____

Employee: Please return completed forms to OptimistPrimeCare Human Resources at the address above.