Washington State Department of Health
DOH 343-144 March 2019

Adult Tuberculosis Risk Assessment

- Use this tool to identify asymptomatic **adults** for latent TB infection (LTBI) testing.
- **Do not repeat testing** unless there are **new risk factors** since last test.
- Do not treat for LTBI until active TB disease has been excluded:
  For patients with TB symptoms or an abnormal chest x-ray consistent with active TB disease, further evaluation may be needed such as: sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.

LTBI testing is recommended if any of the three boxes below are checked.

☐ **Born, live, or travel in a country with an elevated TB rate for at least one month.**

- The duration of at least one consecutive month to trigger testing is intended to identify travel most likely to involve TB exposure.
- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe.
- If resources require prioritization within this group, **prioritize** patients with at least one medical risk for progression (see Adult TB Risk Assessment User Guide for this list).
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-U.S.-born persons ≥ 2 years old.

☐ **Immunosuppression**, current or planned.

HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication.

☐ **Close contact** to someone with infectious TB disease during lifetime.

Treat for LTBI, if LTBI test result is positive and active TB disease is ruled out.

☐ None; no TB testing is indicated at this time.

Provider: _____

Assessment Date: _____

Patient Name: _____

Date of Birth: _____

(Place sticker here if applicable)

See the Adult TB Risk Assessment User Guide (pages 2-3) for more information about using this tool.

Adult TB Risk Assessment User Guide

Avoid testing persons at low risk

Routine testing of low risk populations is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

Prioritize persons with risks for progression

If health system resources do not allow for testing of all persons who are born, traveled, or have lived in a country with an elevated TB rate for at least one month, prioritize patients with at least one of the following medical risks for progression:

- diabetes mellitus
- smoker within the last year
- end stage renal disease
- leukemia or lymphoma
- silicosis
- cancer of head or neck
- intestinal bypass/gastrectomy
- chronic malabsorption
- body mass index ≤ 20
- history of chest x-ray findings suggestive of previous or inactive TB (no prior treatment). Includes fibrosis or non-calcified nodules, but does not include solitary calcified nodule or isolated pleural thickening. In addition to LTBI testing, evaluate for active TB disease.

While immunosuppression does increase the risk of disease progression, it does not increase the risk of TB exposure.

United States Preventive Services Task Force (USPSTF)

The USPSTF has recommended testing persons born-in or former residents of a country with an elevated tuberculosis rate and persons who live in or have lived in high-risk congregate settings such as homeless shelters and correctional facilities. Because the increased risk of exposure to TB in congregate settings varies substantially by facility and local health jurisdiction, clinicians are encouraged to follow local recommendations when considering testing among persons from these congregate settings. The USPSTF did not review data supporting testing among close contacts to persons with infectious TB or among persons who are immunosuppressed because these persons are recommended to be screened by public health programs or by clinical standard of care. Screening Recommendations are available on the USPSTF website. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/latent-tuberculosis-infection-screening

Local recommendations

Local TB control programs and clinics can customize this risk assessment according to local recommendations. **Providers should check with local TB control programs for more information.** Local health jurisdictions contact information can be found on the online at: https://www.doh.wa.gov/AboutUs/PublicHealthSystem/LocalHealthJurisdictions

Mandated testing and other risk factors

Several risk factors for TB that have been used to select patients for TB screening historically or in mandated programs are not included among the components of this risk assessment. This is purposeful in order to focus testing on patients at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede any mandated testing. Examples of these populations include: healthcare workers, residents or employees of correctional institutions, substance abuse treatment facilities, homeless shelters, and others.

Age as a factor

Age (among adults) is not considered in this risk assessment. However, younger adults have more years of expected life during which progression from latent infection to active TB disease could develop.

Children

This risk assessment tool is intended for adults. A risk assessment tool, created for use in children, is available here: https://www.doh.wa.gov/Portals/1/Documents/Pubs/343-145-PediatricTBRiskAssessment.pdf

Foreign travel

Travel to countries with an elevated TB rate may be a risk for TB exposure in certain circumstances (e.g. extended duration, likely contact with an infectious TB patient, high prevalence of TB in travel location, non-tourist travel). The duration of at least one consecutive month to trigger testing is intended to identify travel most likely to involve TB exposure. TB screening tests can be falsely negative within eight weeks after exposure, so are best obtained eight weeks after the last exposure, or return from travel.

Adult TB Risk Assessment User Guide — *continued*

When to repeat a test

Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment. In general, this would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel in certain circumstances.

When to repeat a risk assessment

The risk assessment should be administered at least once. Persons can be screened for new risk factors at subsequent preventive health visits.

IGRA preference in BCG vaccinated

Because IGRA has increased specificity for TB infection in persons vaccinated with BCG, IGRA is preferred over the TST in these persons. Most persons born outside the United States have been vaccinated with BCG.

Previous or inactive tuberculosis

Chest radiograph findings consistent with previous or inactive TB include fibrosis or non-calcified nodules, but do not include a solitary calcified nodule or isolated pleural thickening. Persons with a previous chest radiograph showing findings consistent with previous or inactive TB should be tested for LTBI. In addition to LTBI testing, evaluate for active TB disease.

Negative test for LTBI does not rule out active TB disease

It is important to remember that a negative TST or IGRA result does not rule out active TB disease. Any suspicion for active TB disease or extensive exposure to TB should prompt an evaluation for active TB disease, including physical exam, symptom review, and 2-view chest x-ray.

Symptoms that should trigger evaluation for active TB disease

Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB disease: cough for more than 2-3 weeks, fevers, night sweats, weight loss, hemoptysis.

Most patients with LTBI should be treated

Most patients with LTBI should be treated Persons with risk factors who test positive for LTBI should generally be treated once active TB disease has been ruled out with a physical exam, chest radiograph and, if indicated, sputum smears, cultures, and nucleic acid amplification testing (NAAT). However, clinicians should not feel compelled to treat persons who have no risk factors but have a positive test for LTBI.A helpful online resource to assess an adult's risk of progression to disease based on screening results and risk factors is: http://www.tstin3d.com/

Emphasis on short course for treatment of LTBI

Shorter regimens for treating latent TB infection have been shown to be as effective as 9 months of isoniazid, and are more likely to be completed. Use of these shorter regimens is preferred in most patients. Drug-drug interactions and contact to drug resistant TB are typical reasons these regimens cannot be used.

Shorter duration LTBI treatment regimens

Medication*	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + rifapentine	Weekly	12 weeks

* 11-12 doses in 16 weeks required for completion.

For more information, refer to ***LTBI Treatment Guidance in Washington State*** and one-page ***LTBI Treatment Quick Reference Sheet*** found online at: https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/Tuberculosis/TBProviderToolkit Have questions or need consultation on a LTBI or TB patient? TB ECHO® is a weekly videoconference meeting for healthcare professionals to get TB education, consultation, and mentoring. Learn more at: www.doh.wa.gov/TBECHO.

Patient refusal of recommended LTBI treatment

Refusal should be documented. Recommendations for treatment should be made at future encounters with medical services. If treatment is later accepted, TB disease should be excluded and CXR repeated if it has been more than 6 months from the initial evaluation; or more than 3 months if there is immunosuppression, or the prior CXR was abnormal and consistent with potentially active TB disease.

Jefferson Healthcare

Created: 03/02/2016
ARCHIVED: N/A
OWNER: Employee Health
PURPOSE: New Hire Assessment

Employee Health Screening Questionnaire

Name: _____ Date of Birth: _____Today's Date: _____
Position/Dept: _____ Email: _____
*I authorize JH Employee Health Department to retrieve any vaccination records from the Washington State Immunization Information System. SIGNATURE:_____
Allergies and description of reactions: _____☐NONE
Current Medications: _____☐NONE
Latex Sensitivity Allergy: ☐ Yes ☐ No

Do you have a history of:	YES	NO	If yes, please explain
Asthma, Shortness of Breath, or Lung problems	☐	☐	
Heart, blood pressure problems	☐	☐	
Seizures	☐	☐	
Hepatitis; if yes type: _____	☐	☐	
Diabetes	☐	☐	
Allergic reactions that interfere with breathing.	☐	☐	
Claustrophobia	☐	☐	

Work-Related Injury/Exposures

A previous workers' compensation claim or disability WILL NOT prevent you from working at Jefferson Healthcare if you are able to perform the essential functions of the job with or without reasonable accommodations.

1. Do you currently have a Preferred Worker status or an open Workers' Compensation claim? ☐ Yes ☐ No
   If yes, please explain_____
2. Have you ever had blood-borne pathogen exposure? ☐ Yes ☐ No
   If yes, please explain: _____

HEPATITIS B VACCINATION DECLINATION FORM

OSHA REGULATION (Standard- 29 CFR 1910.1030 App A)

FOR JOBS WITH POTENTIAL EXPOSURE TO BLOOD AND BODY FLUIDS

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring a hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the hepatitis B vaccine, at no charge to myself. However, I **decline** hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the hepatitis B vaccine, I can receive the vaccination series at no charge to me.

I **decline** the Hepatitis B vaccination at this time, due to:

☐Have had vaccination series and will be awaiting titer results ☐Have full vaccination series & positive titer
☐The position does not expose me to blood or infectious material ☐Allergic ☐Starting series

_____ _____
Employee Signature Date

_____ _____
EH Nurse Signature Date

Declining the Hepatitis B vaccination because:

Jefferson Healthcare

Medical Exemption from Mandatory COVID-19 Vaccination

Employee Section. COMPLETE THE FOLLOWING:

Name: _____ Badge#: _____

Department/Location: _____ Work Phone: _____

Manager/Supervisor: _____

Position Title: _____

The information I am submitting to substantiate my request for a medical exemption from the mandatory COVID-19 vaccination requirement for Jefferson Healthcare is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, up to and including termination. I further understand that Jefferson Healthcare is not required to provide an accommodation to mandatory COVID-19 vaccination if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for Jefferson Healthcare.

Employee Signature: _____ Date: _____

After you and your provider complete this form, please fax to Human Resources at 360-385-1548. For questions, please contact Kara Snyder, Human Resources Generalist, at ksnyder@jeffersonhealthcare.org or 360-385-2200 extension 2078.

Provider Section. ***A PHYSICIAN, PA, OR NP LICENSED IN THE STATE OF WASHINGTON MUST COMPLETE AND SIGN THIS SECTION. FORMS COMPLETED BY THE EMPLOYEE WILL NOT BE ACCEPTED. ***

Instructions: By completing this form, you certify that different methods of vaccinating against COVID-19 have been considered, and the following medical contraindication precludes any/all vaccinations for COVID-19. Guidance for medical exemptions for COVID-19 can be accessed regarding "Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States" at: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.htmlPlease select medically indicated contraindication below:

- ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine (Please describe response in detail below and contraindication to alternatives)
- ☐ Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine (Please describe response in detail below and contraindication to alternatives)

Jefferson Healthcare

☐ Other medical circumstance preventing vaccination with any available COVID-19 vaccine, e.g., Pfizer-BioNTech COVID-19 vaccine, Moderna COVID-19 vaccine, or Janssen (Johnson & Johnson) COVID-19 vaccine (Be specific and describe in detail):

_____

_____

_____

This exemption should be:

☐ Temporary, expiring on: ____/____/_____, or when _____.
☐ Permanent

Medical Provider Name (Please Print): _____

Signature: _____ Date: _____

Provider Phone: _____ Provider Fax: _____

Practice Name & Address: _____

Practice email: _____

HR USE ONLY

Date of initial request: __/__/____ Date certification received: __/__/____

Accommodation request:

☐ **Approved** __/__/____ through __/__/____
Describe specific accommodation details and document interactive process:
_____
_____

☐ **Denied** __/__/____
Describe why accommodation is denied:
_____
_____

Jefferson Healthcare

STATUS: Official
CREATED: 3/15/16
ARCHIVED: N/A
OWNER: Employee Health
PURPOSE: Release of Records

EMPLOYEE HEALTH SERVICES
RELEASE OF INFORMATION

Name:_____Date of Birth:_____

Permission is hereby granted for the release of information from:

NAME:_____
LOCATION:_____
FAX:_____

To: Jefferson Healthcare
Employee Health Services
834 Sheridan Street
Port Townsend, WA 98368
Fax: 360-344-1006

I give permission for this information to be used for the purpose of supplementing my occupational health record, for job-related functions, and for the scope of any resultant accommodations. I request the following information be released:

X_ Most Recent PPD(s)/ T-Spot/ Quantiferon Gold Lab
X_ Hepatitis B/ Measles/ Mumps/ Rubella/ Varicella Titers
X_ Hepatitis B Vaccinations(s)
X_ MMR/ Varicella Vaccination(s)
X_Current annual Influenza/ Tdap/ COVID-19 Vaccination(s)
☐ Medical Records (Specify): _____
☐ Previous Injury: Must have a completed Return to Work Authorization form.
Date of Injury: _____ Claim # _____

This authorization expires 90 days from the date signed. This consent is subject to revocation at any time by me in writing except to the extent that action has been taken.

_____ _____
Signature Date

_____ _____
Witness Signature Date

Jefferson Healthcare

Request for Religious Reasonable Accommodation from Mandatory COVID-19 Vaccination

Employee Section. COMPLETE THE FOLLOWING:

Name: _____ Badge#: _____

Department/Location: _____ Work Phone: _____

Manager/Supervisor: _____

Position Title: _____

Identify your sincerely-held religious observance, belief, or practice:

_____

_____

Describe the way in which obtaining any of the available COVID-19 vaccinations (Pfizer-BioNTech COVID-19 vaccine, Moderna COVID-19 vaccine, Janssen (Johnson & Johnson) COVID-19 vaccine) conflict with your sincerely-held religious observance, belief or practice:

_____

_____

_____

_____

Length of time the accommodation is needed: _____

Describe any accommodations that might permit you to become fully vaccinated while addressing the conflict you described above (for example, obtaining a vaccine that does not include certain materials):

_____

_____

_____

_____

I have read and understand Jefferson Healthcare's policy on religious accommodation. My religious beliefs and practices, which result in this request for a religious accommodation, are sincerely held. I understand that the accommodation requested above may not be granted if providing an accommodation creates an undue hardship or poses a direct threat to my safety or the safety of others. I understand that Jefferson Healthcare may need to obtain supporting documentation regarding my religious practice and beliefs to further evaluate my request for a religious accommodation.

Jefferson Healthcare

The information on this form and my statement regarding this conflict (as completed below) are complete and correct. I understand that any falsified information can lead to disciplinary action, up to and including termination.

Employee Signature: _____ Date: _____

After you complete this form, please fax to Human Resources at 360-385-1548. For questions, please contact Kara Snyder, Human Resources Generalist, at ksnyder@jeffersonhealthcare.org or 360-385-2200 extension 2078.

HR USE ONLY

Date of initial request: __/__/____ Date certification received: __/__/____

Accommodation request:

☐ Approved __/__/____

Describe specific accommodation details and document interactive process:

_____
_____
_____

☐ Denied __/__/____

Describe why accommodation is denied (if direct threat or undue hardship, specifically describe):

_____
_____
_____

If the requested accommodation is denied, what are some alternative accommodations (list in order of preference):

1. _____
2. _____
3. _____

Date discussed with employee: ____/____/_____

Final accommodation agreed upon: _____

Jefferson Healthcare

If no agreement on an accommodation, describe the interactive process with the employee:
_____
_____
_____

Human Resources signature: _____ Date: _____

Jefferson Healthcare

CREATED 3/3/16
ARCHIVED: N/A
OWNER: Employee Health
PURPOSE: Respiratory Questionnaire

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE
(Required and Adapted from WISHA/OSHA Respiratory Protection Program 29 CFR 1910.134)

TO THE EMPLOYEE:

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your director or supervisor must not look at or review your answers. This is kept in your occupational health record in Employee Health which is separate from your personnel file kept in Human Resources.

PART 1

Section 1 (Mandatory): The following information must be provided by every employee who has been selected to use any type of respirator (please PRINT).

NAME_____ DOB_____ BADGE NUMBER _____

DEPT_____TODAY'S DATE_____ GENDER ☐Male ☐Female

HEIGHT_____ft _____in WEIGHT_____ JOB TITLE_____

A phone number where you can be reached by the health care professional who reviews this questionnaire (include Area Code)_____

WHAT TYPE OF RESPIRATOR(S) WILL YOU BE USING? (you can check more than one)

☐N95 disposable respirator (filter mask, non-cartridge only) ☐Other type (half/full face mask, PAPR, SCBA, Surgical)

Have you ever worn a respirator? ☐No ☐Yes, what type(s) _____

Part 2 (Mandatory): QUESTIONS 1- 9 BELOW MUST BE ANSWERED BY EVERY EMPLOYEE WHO HAS BEEN SELECTED TO USE ANY TYPE OF RESPIRATOR.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes ☐ No ☐

2. Have you ever had any of the following conditions?
   ☐ Seizures (fits) ☐ Diabetes (sugar disease) ☐ Allergic reactions that interfere with your breathing ☐ Trouble smelling odors
   ☐ Claustrophobia (fear of closed-in places)
   ☐ NONE OF THE ABOVE

3. Have you ever had any of the following pulmonary or lung problems?
   ☐ Asbestosis ☐ Asthma ☐ Chronic bronchitis ☐ Emphysema ☐ Pneumonia ☐ Tuberculosis (TB) ☐ Silicosis
   ☐ Pneumothorax (collapsed lung) ☐ Lung cancer ☐ Broken ribs ☐ Any chest injuries or surgeries
   ☐ Any other lung problems you've been told about_____
   ☐ NONE OF THE ABOVE

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   ☐ Shortness of breath ☐ Shortness of breath when walking on level ground or walking up a slight hill or incline
   ☐ Shortness of breath when walking with other people at an ordinary pace on level ground
   ☐ Have to stop for breath when walking at your own pace on level ground ☐ Shortness of breath when washing or dressing
   ☐ Shortness of breath that interferes with your job ☐ Coughing that produces phlegm (thick sputum)
   ☐ Coughing that wakes you early in the morning ☐ Coughing that occurs mostly when you are lying down
   ☐ Coughing up blood in the last month ☐ Wheezing ☐ Wheezing that interferes with your job
   ☐ Chest pain when you breathe deeply ☐ Any other symptoms that you think may be related to lung problems
   ☐ NONE OF THE ABOVE

5. Have you ever had any of the following cardiovascular or heart problems?
   ☐ Heart attack ☐ Stroke ☐ Angina ☐ Heart failure ☐ Swelling in your legs or feet (not caused by walking)
   ☐ Heart arrhythmia (irregular heartbeat) ☐ High blood pressure ☐ Any other heart problems you've been told about
   ☐ NONE OF THE ABOVE

6. Have you ever had any of the following cardiovascular or heart symptoms?
   ☐ Frequent pain or tightness in your chest ☐ Pain or tightness in your chest during physical activity
   ☐ Pain or tightness in your chest that interferes with your job ☐ past two years, noticed your heart skipping or missing a beat
   ☐ Heartburn or indigestion not related to eating ☐ Any other symptoms that you think may be related to heart problems
   ☐ NONE OF THE ABOVE

7. Do you currently take medication for any of the following problems?
   ☐ Breathing or lung problems ☐ Heart trouble ☐ Blood pressure ☐ Seizures (fits)
   ☐ NONE OF THE ABOVE

8. If you have used a respirator, have you ever had any of the following?
   ☐ Eye irritation ☐ Skin allergies/rashes ☐ Anxiety ☐ General weakness/fatigue
   ☐ Any problem that interferes with your use of a respirator ☐ Any significant structural changes to your face/head
   ☐ NONE OF THE ABOVE

9. Would you like to talk with a healthcare professional who will review this questionnaire about your answers to this questionnaire?
   ☐ YES ☐ NO

JEFFERSON HEALTHCARE EMPLOYEE HEALTH SERVICES

*I have been educated on *the instructions for use, reasons for usage, donning and doffing, storage, and replacement indicators for this respirator.* *

Badge ID#:_____ Dept: _____

Name: _____ DOB: _____

Employee Signature: _____Date:_____

Mask fitted for: 3M 1860S/ 1804/ 1870+/ 1860/ CAPR/ Surgical Mask

Fit Process: Qualitative Saccharin/Biterex or Quantitative Machine Fit Test

◯ **Voluntary N95 usage: OSHA Appendix D to Sec. 1910.134 form provided: _____**

Person reviewing this questionnaire/performing testing/educating employee:

(EH Nurse/ designee) _____ Date_____

Jefferson Healthcare

CREATED: 3/7/16
ARCHIVED: N/A
OWNER: Employee Health
PURPOSE: TB Medical Screen

TB SYMPTOM SCREENING SAFETY PROGRAM
MEDICAL QUESTIONNAIRE SURVEILLANCE

PURPOSE:

Tuberculosis (TB) screening through use of this medical questionnaire is required for all employees as an assessment tool who are a new hire or have had a prior positive TB skin test or positive Interferon Gamma Release Assay (IGRA) lab test. An annual chest x-ray is not recommended by the Centers for Disease Control unless employee is symptomatic. TB is transmitted by people with active TB who cough, sneeze, talks, or sings in the vicinity of others. Latent tuberculosis has the potential to activate in times of stress or when the body is immunocompromised and spread disease to others, including friends, family, and patients. Latent TB is treatable! If you have been diagnosed with latent TB It is highly recommended to see your medical provider if you have not been treated for latent TB infection (LTBI).

YOU MAY FAX THIS FORM TO 344-1006, BRING IN, OR SEND ORIGINAL IN INTEROFFICE MAIL.

NAME:_____ **BADGE#:**_____ **DATE:**_____

DEPT: _____**SIGNATURE**_____

Have you ever had or do you now have any of the following:

		*YES	NO
1.	Persistent cough longer than 3 weeks	☐	☐
2.	Night sweats	☐	☐
3.	Unexplained weight loss	☐	☐
4.	Unusual fatigue	☐	☐
5.	Anorexia (loss of appetite) for more than two months	☐	☐
6.	Hemoptysis (coughing up blood)	☐	☐
7.	Persistent temperature elevations over the past few months	☐	☐
8.	History of active TB within the past year or recently diagnosed TB and no subsequent disease inactivity	☐	☐
9.	Exposure to person with active TB in the past 2 years without personal protection equipment	☐	☐
10.	Abnormal chest x-ray (upper lobe infiltrates, cavitation, other infiltrates - if no other cause)	☐	☐
11.	History BCG vaccination (vaccine against TB)	☐	☐
12.	History of positive Quantiferon Gold or T-Spot (blood test confirming TB)	☐	☐
13.	Current use of immunosuppressive medications	☐	☐
14.	Have you ever had past 3-9 months of INH antibiotic therapy for TB **(If Yes- please send in record of INH treatment completion)**	☐	☐

***Please explain YES answers:** _____