TRINITY CARE XYZ

Orientation to the Case Attestation

Patient _____ **DOB:** _____/_____/_____

Date	CHHA/Field Nurse *Initials**	Plan of care Review	Nursing Supervisor *initials**	Where/how performed?
		YES NO		
Special Instructions:				

Date	CHHA/Field Nurse Initials*	Plan of care Review	Nursing Supervisor initials*	Where/how performed?
		YES NO		
Special Instructions:				

Date	CHHA/Field Nurse Initials*	Plan of care Review	Nursing Supervisor initials*	Where/how performed?
		YES NO		
Special Instructions:				

Date	CHHA/Field Nurse Initials*	Plan of care Review	Nursing Supervisor initials*	Where/how performed?
		YES NO		
Special Instructions:				

*Initial Key:

Initials Nanne/Title (Print) _____ Signature _____

Orientation to the Case

Patient _____ DOB: _____/_____/__

Initial Key:

Initials	Name/Title (Print)	Signature

CAHC SAMPLE

Alternate Assessment - TB Screening Questionnaire

Employee Name: _____

This form is completed annually for those employees who have documentation of a negative chest x-ray following a positive Mantoux screening test, and whose medical evaluation and chest x-ray indicate that no further Mantoux screening is required.

Do you experience any of the following:	Yes	No
• bad cough that lasts longer than 2 weeks	☐	☐
• coughing up sputum (phlegm)	☐	☐
• coughing up blood	☐	☐
• loss of appetite	☐	☐
• weakness/fatigue/tiredness	☐	☐
• night sweats	☐	☐
• unexplained weight loss	☐	☐
• fever	☐	☐
• chills	☐	☐
• chest pain	☐	☐

Have you recently spent time with someone who has infectious tuberculosis? ☐ Yes ☐ No

Any other complaints? ☑ Yes ☐ No If yes, explain:

The above health statements are accurate to the best of my knowledge. I have been inserviced on the signs and symptoms of tuberculosis and been advised to seek medical care if any of the symptoms develop at any time.

Employee Signature: _____ Date: _____

Nurse Reviewer Recommendation

☐ Refer employee for medical evaluation immediately, before continuing work.
☐ No action to be taken at this time.

RN Signature: _____ Date: _____

TRINITYCARE.XYZ

ANNUAL IN-SERVICE SIGN-IN SHEET

In-service Title: _____

Date: _____ **Teacher:** _____

Print Name	Signature	Last 4 of s.s