

UNITED STATES DISTRICT COURT		SOUTHERN DISTRICT OF TEXAS	
DR. ORLY TAITZ v. JEH JOHNSON, SECRETARY OF DEPARTMENT OF HOMELAND SECURITY, ET AL.		BROWNSVILLE DIVISION	
		CIVIL ACTION No. B-14-119	
		EXHIBIT LIST	
LIST OF: GOVERNMENT EXHIBITS TYPE OF HEARING: INJUNCTION		AUSA: DANIEL D. HU & COLIN KISOR	
JUDGE: ANDREW S. HANEN	CLERK: CRISTINA SUSTAETA	REPORTER: BARBARA BARNARD	

No.	DESCRIPTION	OFR	OBJ	ADM	DATE
1.	Memorandum from Secretary of Homeland Security Janet Napolitano, Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children (June 15, 2012): http://www.dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf				
2.	DR. MIGUEL ESCOBEDO, CV				
3.	DHS Occupational Health Advisory – May 1, 2014				
4	CDC LETTER TO PHYSICIANS AUGUST 7, 2014				
5	ADMINISTRATION FOR CHILDREN AND FAMILIES – LETTER TO TB CONTROLLERS				
6.	HHS LETTER TO HEALTH CARE PROVIDERS – GUIDANCE ON CLEARING UAC WITH TB				
7.	ACTIVE TB SCREENING ALGORITHM				
8.	NEDSS TEXAS REPORTING INSTRUCTIONS AND FORM				
9.	CDC GUIDELINES FOR PREVENTING THE TRANSMISSION OF TUBERCULOSIS IN HEALTH CARE SETTINGS - 2005				
10.	PRIOR COURT TESTIMONY OF CHIEF OAKS, MR. FIERRO AND Ms. BROOKS – 8/27/2014				
11.	CDC TB ELIMINATION SHEET WWW.CDC.GOV/TB/PUBLICATIONS/FACTSHEETS/TESTING/DIAGNOSIS.PDF				
12.					

CERTIFICATE OF SERVICE

Counsel of record was served by ECF on October 27, 2014

/s/Daniel Hu

Daniel Hu

MIGUEL ESCOBEDO, MD., MPH.

CURRICULUM VITAE (Summary)

Education:

- Stanford University School of Medicine, MD
- University of California at Berkeley, MPH
- New Mexico State University, BS Biology

Residency/Fellowship Program:

- Family Practice Residency – Texas Tech Medical School

Current Practice Type and/or Employer:

- Medical Officer - Centers for Disease Control and Prevention, US-MX Border Unit, El Paso Quarantine Station

Professional Experience:

- Quarantine Medical Officer – Centers for Disease Control and Prevention
- February 2005 to present
- District Health Officer – New Mexico Department of Health, Dist. III
January 2003 to October 2003
- Regional Director – Texas Department of Health, Public Health Region 9/10
January 1996 to January 2003 and October 2003 to February 2005
- Tuberculosis Control Officer – El Paso City-County Health District
April 1986 to December 1996
- Medical Director, Communicable Diseases Control- El Paso City-County Health District
- Medical Director, Preventive Health Services, El Paso City-County Health District
- Family Medicine Physician, El Paso Centro de Salud Familiar La Fe (Certified Community Health Center)
- Seasonal Agricultural Worker.

Other Pertinent Information:

- WHO consultant, International Health Regulations
- Served on National Advisory Council for TB Elimination - CDC
- Served on Council of Public Health - Texas Medical Association
- Fratis L. Duff M.D. Memorial Award, Texas Health Foundation
- Voting member, Texas Department of Health Institutional Review Board for Human Subjects

Research Interests:

- **Border Health Issues**
- **Quarantine & Traveler's health**
- **Bi-national Tuberculosis Control**

Dr. Escobedo is currently a Medical Health Officer with the Centers for Disease Control Quarantine Station in El Paso. He is past Regional Director for the Texas Department of State Health Services Regions 9/10 and Regional District Health Officer for the New Mexico Department of Health. He served as Tuberculosis and Control Officer and Communicable Diseases Director for El Paso City- County Health District for 10 years. Dr. Escobedo is a graduate of Stanford University School of Medicine and the University of California Berkeley School Of Public Health. He completed a Family Practice Residency Program at Texas Tech El Paso. His research interests include Tuberculosis, Border Health, and Quarantine and Travelers Health. He has authored articles in Public Health Journals.



Occupational Health Advisory

May 1, 2014

TO: CBP

SUBJECT: Scabies Outbreak

This document sets forth occupational health and safety guidance for CBP personnel in the handling of subjects presenting with the signs and symptoms of scabies.

Human scabies is caused by an infestation of the skin by the human itch mite (*Sarcoptes scabiei* var. *hominis*). The microscopic scabies mite burrows into the upper layer of the skin where it lives and lays its eggs. The scabies mite usually is spread by direct, prolonged, skin-to-skin contact with a person who has scabies. Occasionally transmission occurs from direct skin contact with clothing or bedding from an infected person.

Scabies can spread rapidly under crowded conditions where close body contact is frequent. Institutions such as extended-care facilities, detention centers and prisons are often sites of scabies outbreaks.

The most common symptoms of scabies are intense itching and a skin rash. These symptoms are caused by an allergic reaction to the proteins and feces of the parasite. Severe itching, especially at night, is the earliest and most common symptom of scabies. A pimple-like rash is also common.

Itching and rash may affect much of the body, but is usually limited to these common sites:

- Between the fingers
- Wrist
- Elbow
- Armpit
- Penis
- Nipple
- Waist
- Shoulder blades
- Buttocks

The head, face, neck, palms, and soles are involved in infants and very small children, but usually not adults and older children.

Tiny burrows are sometimes seen on the skin; these are caused by the female scabies mite tunneling just beneath the skin. The burrows appear as tiny raised and crooked grayish-white or skin colored lines on

This Safety and Health Information Bulletin is not a standard or regulation, and it creates no new legal obligations. The Bulletin is advisory in nature, for internal DHS use only; informational in content, and is intended to assist supervisors and employees in providing a safe and healthful workplace. For more information about Office of Health Affairs Health Advisories, contact the OHA Watch Desk at NOC.OHA@hq.dhs.gov or 202-282-9262.

the skin surface. They are most often found in the webbing between the fingers, in the folds of the skin on the wrist, elbow, or knee.

Complications associated with scabies are usually caused by infection of the sores caused by scratching. A more severe form of scabies, called crusted scabies, may affect certain high-risk groups, including: people with chronic health conditions that weaken the immune system, such as HIV or leukemia; people who are very ill, such as hospitalized individuals or those in nursing facilities.

Infectious Period: When a person is infested with scabies mites the first time, symptoms usually do not appear for up to 2-6 weeks after being infested. Infested person(s) can still spread scabies even if they are not exhibiting symptoms. If a person has had scabies before, symptoms appear much sooner, 1-4 days after exposure.

Scabies mites generally do not survive more than 2 to 3 days away from human skin. Adults and children can return to work or school a day after treatment was started.

Personal protective equipment: Latex or non-latex gloves should be used anytime direct contact will be made with any subjects that are confirmed or suspected of having scabies.

Treatment: The following medications for the treatment of scabies are available only by prescription.

Prescriptions:

A) Permethrin cream 5%; Brand name product: Elimite*

Permethrin is approved by the US Food and Drug Administration (FDA) for the treatment of scabies in persons who are at least 2 months of age. Permethrin is a synthetic pyrethroid similar to naturally occurring pyrethrins which are extracts from the chrysanthemum flower. Permethrin is safe and effective when used as directed. Permethrin kills the scabies mite and eggs. Permethrin is the drug of choice for the treatment of scabies. Two (or more) applications, each about a week apart, may be necessary to eliminate all mites, particularly when treating crusted (Norwegian) scabies. Treatment for confirmed or suspected cases of scabies will be Permethrin 1% lotion. The medication should be applied directly to the skin on all areas of the body except the head. After application, the medication will be left on the skin for 24 hours before being washed off. During application and rinsing contact with the eyes, the inside of the mouth, nose and vagina should be avoided as it will cause irritation. Due to potential complications, treatment for pregnant females is optional. Prescription permethrin, such as Elimite cream, is the most commonly used medicine to treat scabies. Unlike the more toxic lindane, permethrin is considered safe for infants as young as 2 months old. Only permethrin, crotamiton, and sulfur ointment are considered safe for treating children younger than age 2.

B) Crotamiton lotion 10% and Crotamiton cream 10%; Brand name products: Eurax*; Crotan*
Crotamiton is approved by the US Food and Drug Administration (FDA) for the treatment of scabies in adults; it is considered safe when used as directed. Crotamiton is not FDA-approved for use in children. Frequent treatment failure has been reported with crotamiton.

C) Lindane lotion 1%; Brand name products: None available

Lindane is an organochloride. Although FDA-approved for the treatment of scabies, lindane is not recommended as a first-line therapy. Overuse, misuse, or accidentally swallowing lindane can be

toxic to the brain and other parts of the nervous system; its use should be restricted to patients who have failed treatment with or cannot tolerate other medications that pose less risk. Lindane should not be used to treat premature infants, persons with a seizure disorder, women who are pregnant or breast-feeding, persons who have very irritated skin or sores where the lindane will be applied, infants, children, the elderly, and persons who weigh less than 110 pounds.

D) Ivermectin; Brand name product: Stromectol*

Ivermectin is an oral antiparasitic agent approved for the treatment of worm infestations. Evidence suggests that oral ivermectin may be a safe and effective treatment for scabies; however, ivermectin is not FDA-approved for this use. Oral ivermectin has been reported effective in the treatment of crusted scabies; its use should be considered for patients who have failed treatment with or who cannot tolerate FDA-approved topical medications for the treatment of scabies. The dosage of ivermectin is 200 mcg/kg orally. It should be taken on an empty stomach with water. A total of two or more doses at least 7 days apart may be necessary to eliminate a scabies infestation. The safety of ivermectin in children weighing less than 15 kg and in pregnant women has not been established.

E) Persistent nodular scabies may be treated with injections of steroids into the nodules or (rarely) with coal tar products applied to the skin.

For Itching:

Use of the following over-the-counter medicines can help relieve itching from scabies:

- A) Oral antihistamines (such as Benadryl). These medicines will not interfere with the diagnosis or treatment of scabies. Don't give antihistamines to your child unless you've checked with the doctor first.
- B) Corticosteroid creams (such as hydrocortisone cream). This type of medicine may make the scabies sores look different and make it harder for your doctor to diagnose the problem. Only use this medicine after your doctor has seen and diagnosed your condition.

Most creams or lotions are applied to the entire body from the neck down. On infants, the medicine is also applied to the scalp, face, and neck, taking care to avoid the area around the mouth and eyes. The medicine usually is left on for 8 to 14 hours and then washed off.

Hygiene Guidance:

Immediately after starting treatment for scabies, clean all the affected person's bedding and the clothing that he or she has worn during the past 2 to 3 days (48 to 72 hours). Wash all items in hot water and dry them in a hot dryer. Or dry-clean them.

Any items that cannot be washed or dry-cleaned must be placed in a closed plastic bag for at least 7 days.



August 7, 2014

Dear Colleagues:

The purposes of this letter are to give you an overview of the tuberculosis (TB) control efforts for unaccompanied children who come into the care and custody of the Department of Health and Human Services after being apprehended by immigration authorities and to let you know about situations when your help might be needed.

When children apprehended by immigration authorities are unaccompanied by a parent or guardian, they are placed in the care and custody of the Department of Health and Human Services (HHS). Typically, HHS then releases children to an appropriate sponsor—usually a parent, relative, or family friend—who can safely and appropriately care for them while their immigration cases proceed. The Administration for Children and Families Office of Refugee Resettlement (ORR) at HHS operates about 100 short-term shelters in 14 states that care for the unaccompanied children until they are released to sponsors.

Most children remain in a shelter for less than 35 days and are released to appropriate sponsors while their immigration cases are processed. Children are not released to a sponsor if they have a medical condition that is a public health threat. When a child is released to a sponsor, the child moves to the community in which the sponsor lives. Although the children are in ORR custody, they are not refugees in the legal sense, and they do not currently qualify for federal refugee benefits.

After admission to a shelter, each child undergoes health examinations, including TB screening that is modeled on the Technical Instructions for Tuberculosis Screening and Treatment for panel physicians developed by the CDC Division of Global Migration and Quarantine. This screening starts with a symptom inventory for all children regardless of age. For children 15–17 years old, the shelter healthcare providers have a choice between (1) chest radiography with further diagnostic tests as needed for radiographic abnormalities or (2) initial testing with either a tuberculin skin test or an interferon-gamma release assay. Children 2–14 years old undergo either a tuberculin skin test or an interferon-gamma release assay, with the skin test preferred for children younger than 5 years old. Children younger than 2 years of age undergo no TB-specific testing unless they are known to have been exposed to contagious TB or have signs or symptoms of TB.

The provisions for health care are different at each shelter. At some shelters, the clinic of the local health department provides services for at least part of the TB screening. Per ORR policy, the medical services offered by a shelter are required to follow local laws about reportable conditions, including suspected or confirmed TB. Through this screening, a small number of cases of TB have been identified. A local health department has been involved in the initial TB care in each confirmed case that has come to our attention. Children who have TB diagnosed during ORR custody are treated and kept in isolation at the shelter until the TB is non-contagious. When a child being treated for TB who is no longer contagious is released to a sponsor, the TB management is transferred from the local health department in the shelter's community to the health department in the community where the sponsor resides.

If the U.S. TB case definition and the usual counting criteria are met, TB programs should report TB cases among unaccompanied children in their jurisdictions for routine surveillance. The standard data fields that are sent to CDC cannot distinguish the children as unaccompanied.

After a diagnosis of latent *Mycobacterium tuberculosis* infection (LTBI), few children in ORR custody start treatment because the duration of custody is brief. Instead, ORR officials notify the destination state's TB control authority with the child's name, diagnostic findings, and sponsor address (see ORR letter, attached). The personnel at ORR shelters collaborate with state or local public health authorities when initiating contact investigations after TB exposures within shelters. For children who were included in a contact investigation, but not completely examined before release from custody to a sponsor, ORR uses the same type of notification to state officials that includes details about the exposure. Neither ORR nor CDC is asking for disposition results of contacts after referrals to state officials.

We learned of one instance when TB was diagnosed after a child was released from ORR custody, and the local TB control official reported it to officials at ORR. Thanks to these efforts, a contact investigation was initiated for children and ORR shelter workers who were possibly exposed. Should this type of event occur in your jurisdiction, please notify the Director, Division of Refugee Health, ORR, at curi.kim@acf.hhs.gov, and the medical coordinators, at ducsmedical@acf.hhs.gov that TB has been diagnosed in a child who has left ORR custody. To initiate a contact investigation, the officials at ORR need at least the child's name and alien number. If your regulations forbid transmission of personally identifiable information by email, you can schedule a telephone verbal report with ORR officials after you contact them by email. ORR does not plan to provide summary data from contact investigations to CDC or to you; therefore, you might not receive data about contacts for your Aggregate Report for Program Evaluation (ARPE).

The TB Program Consultants in the Field Services and Evaluation Branch, Division of Tuberculosis Elimination, CDC, are temporarily assisting ORR personnel with collecting information about suspected TB cases in unaccompanied children. Because some of the information is at local health departments, the TB Program Consultants might ask for your assistance. This is a short-term project, and we do not expect it to require much of your time.

Thank you for your help. If you have questions about TB control for unaccompanied children in your jurisdiction, please contact the CDC TB Program Consultant (see <http://www.cdc.gov/nchhstp/programintegration/MapStateLinks.html>) who is assigned to your jurisdiction as the federal cooperative agreement project officer for your TB control program.

Sincerely,



Philip LoBue, MD, FACP, FCCP

Director

Division of Tuberculosis Elimination

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Centers for Disease Control and Prevention



ADMINISTRATION FOR
CHILDREN & FAMILIES
370 L'Enfant Promenade SW, Washington DC 20447 www.acf.hhs.gov

Dear TB Controller,

Unaccompanied alien children (UAC) are undocumented migrant children who come to the United States without a parent or guardian. Many UAC are apprehended by the Department of Homeland Security (DHS) at the southern border. DHS then transfers UAC to the custody of the Department of Health and Human Services, specifically the Administration for Children and Families' Office of Refugee Resettlement (ORR). Despite being in ORR custody, UAC are *not* legally refugees and do not qualify for refugee benefits. ORR provides UAC with a safe and appropriate environment as well as client-focused care until they are released to a sponsor in the United States or returned to their home country. UAC receive initial medical exams, which include TB screening, upon entering ORR custody.

As most UAC are in short-term custody, if a minor is diagnosed with latent TB infection (LTBI), prophylactic treatment is generally not started. Some UAC with initial negative TB tests who are recent contacts of infectious TB cases may no longer be in ORR custody by the time their second TB tests are due.

This letter is to notify you that ORR has discharged a minor either with LTBI or who has been exposed to infectious TB but has not completed LTBI evaluation. The child will be living in your state. Identifying and clinical information is enclosed.

Thank you.

Sincerely,

Curi Kim, MD, MPH
Director, Division of Refugee Health
Office of Refugee Resettlement



DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES
370 L'Enfant Promenade, S.W.
Washington, D.C. 20447

Dear Healthcare Provider,

The Office of Refugee Resettlement/Division of Children Services/Unaccompanied Alien Children (UAC) Program is providing guidance on clearing UAC with suspected or confirmed active tuberculosis (TB) for release from ORR custody and travel. This guidance is consistent with the Centers for Disease Control and Prevention (CDC)'s algorithm for determining when to clear a patient with suspected or confirmed TB for travel on a commercial aircraft.

The algorithm is primarily intended to guide decisions for pulmonary, pleural, or laryngeal TB in persons aged ≥ 10 years. In general, persons with extrapulmonary TB disease and young children with TB disease are unlikely to pose a public health risk.

A UAC suspected or confirmed to have TB, who does not have or is not at high risk for having multidrug-resistant (MDR) TB, can be cleared for release and travel IF the child is smear negative (3 consecutive negative smears and no subsequent positive smears) AND has been treated for ≥ 1 week with an appropriate regimen AND has been referred to the TB control program of the local health department in the community to which the child will be released. Refer to the charts below:

If cultures or drug susceptibility testing (DST) pending,

AFB Smear + or Cavity on Chest X-ray	TB Culture	High Risk for MDR ^a	Current Treatment	Cleared to travel?	Criteria to be cleared for travel
Yes	Unknown	No	N/A	No	1) 3 consecutive negative AFB smears with no subsequent positive smears <u>and</u> 2) Tx for ≥ 2 weeks with appropriate regimen
Yes	Unknown	Yes	N/A	No	Await DST results and manage accordingly
No	Unknown	No	≥ 1 week	Yes	Not applicable
No	Unknown	No	< 1 week	No	Tx for ≥ 1 week with appropriate regimen
No	Unknown	Yes	N/A	No	Await DST results and manage accordingly

If NOT MDR TB

AFB Smear+ or Cavity on Chest X-ray	TB Culture	MDR Status	Current Treatment	Cleared to travel?	Criteria to be cleared for travel
Yes	+	No	N/A	No	1) 3 consecutive negative AFB smears with no subsequent positive smears <u>and</u> 2) Tx for ≥ 2 weeks with appropriate regimen
No	+	No	≥ 1 week	Yes	Not applicable
No	+	No	< 1 week	No	Tx with appropriate regimen for ≥ 1 week

^a MDR TB is resistant to isoniazid and rifampin. A person is considered high-risk for MDR if (1) a molecular diagnostic test on a respiratory specimen has shown mutations consistent with rifampin resistance, or he or she (2) was a known contact of an MDR TB case, or (3) has had a prior episode of treatment for TB disease or (4) has resided for >1 year in a country from which TB cases reported in the United States occurring in persons born in that country have a high proportion of MDR TB. Based on the U.S. National TB Surveillance System in 2004-2010, these are BELAUS, BHUTAN, DOMINICAN REPUBLIC, ESTONIA, HUNGARY, KAZAKHSTAN, KYRGYZSTAN, LAOS, LATVIA, LITHUANIA, MOLDOVA, MONGOLIA, NEPAL, PERU, RUSSIA, THAILAND, UKRAINE, and SUDAN. This list is updated yearly.

A UAC who the health department is counting and treating as a clinical case of TB disease, even in the absence of respiratory specimens (despite attempts at sputum induction), must be treated for ≥ 1 week with an appropriate regimen before being cleared for release or travel.

A UAC with MDR TB must have two negative cultures obtained after ≥ 2 weeks of treatment (and no subsequent positive cultures) and treatment for ≥ 4 weeks with an appropriate regimen before being cleared for release or travel.

This algorithm may not apply to all situations and certain exceptions may be made on a case-by-case basis, especially if air travel is not involved. For example, for UAC being released locally, earlier release than indicated by the algorithm may be possible. For unusual or complicated cases, please work with the UAC program provider (shelter, foster care, etc.) to consult the ORR Medical Team.

The key to assuring a favorable medical outcome for the UAC and protecting public health is a smooth transfer of care from the current TB control program to the receiving one. The current TB control program should make the interjurisdictional notification to coordinate care with the receiving TB control program before the minor is released from ORR custody. This should be documented by the UAC program provider.

For UAC with suspect or confirmed TB who may be repatriated back to their home country, referral is still indicated. UAC to be repatriated back to Mexico or Central America should be referred to the CureTB program before discharge from ORR custody: http://www.sdcounty.ca.gov/hhsa/programs/phs/cure_tb/ UAC to be repatriated to Central America or any other country should be referred to TBNet before discharge from ORR custody: <http://www.migrantclinician.org/services/network/tbnet.html> In addition, referrals can also be made to CureTB or TBNet to obtain information about UAC previously diagnosed with TB in their country of origin.

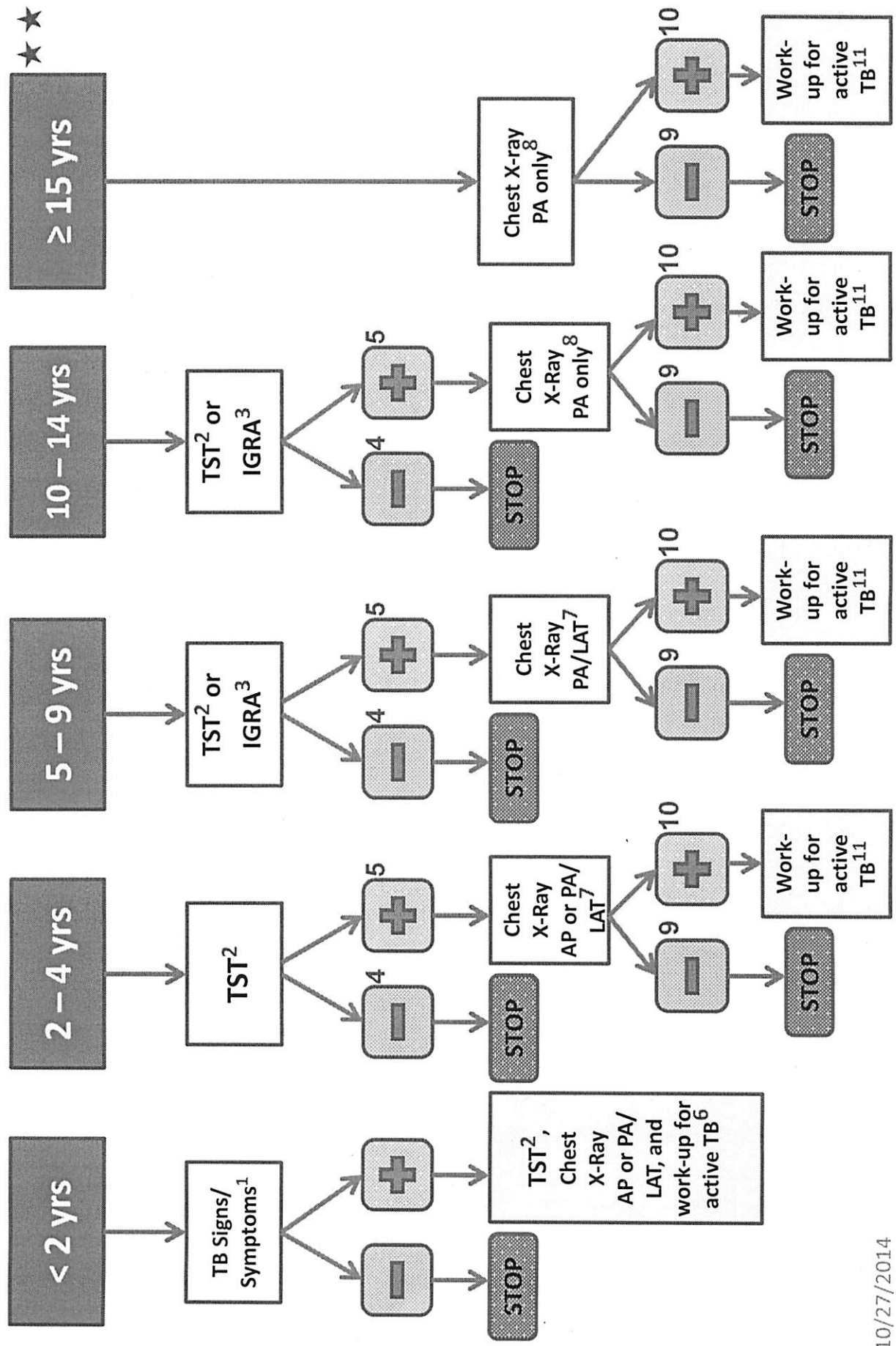
Thank you for taking care of these most vulnerable of children in the U.S.

Sincerely,



Curi Kim, MD, MPH
Medical Officer
Office of Refugee Resettlement
Administration for Children and Families

Active TB Screening Algorithm for UAC in ORR/DCS Care ★





TB/HIV/STD/ Viral Hepatitis
Epidemiology and Surveillance

Instructions for Reporting Tuberculosis (TB) Identified Among Unaccompanied Alien Children (UAC)

Effective June 6, 2014

Updated: August 29, 2014

The Department of State Health Services (DSHS), TB/HIV/STD/Viral Hepatitis Epidemiology and Surveillance Branch (Branch) is enhancing its reporting mechanism to capture UAC ages 0 – 17 years that are referred to a local health department or health service regional TB program for evaluation for TB effective June 6, 2014.

A simple worksheet with instructions have been sent to all case registries for weekly reporting of UAC identified with TB infection, suspicion of disease or confirmed TB disease.

Reporting UAC Using the Report of Verified Cases of TB (RVCT) Form

1. **Report all TB cases, suspects and infections** identified among UAC to the Branch **within 24 hours of diagnosis using the RVCT form.**
2. Include the name (be specific) of the shelter on the street address section of the RVCT. Branch staff will enter the name of the shelter on Adress1 and the physical address on Adress2.
3. If an unaccompanied minor is evaluated for TB infection or disease after being placed in "sponsored custody", please include on your weekly reporting form. Enter "sponsored custody" in the column, "shelter name".
4. For question # 25, "Primary Reason Evaluated for TB Disease", default to targeted testing.
5. For question #29, "Resident of Long-Term Care Facility", default to yes and enter "type" as residential facility.
6. Send all UAC RVCT reporting forms via PHIN in a separate WinZip file. Clearly indicate that the reporting forms are for reporting UAC.



Texas Department of State Health Services Tuberculosis Symptom Screening Form

Name: _____ DOB: _____

Facility Name: _____

Person completing form: _____ Title _____ Date _____
Print Name

Upon intake, all clients should be screened for symptoms consistent with tuberculosis. Please ask all clients during the intake process if they have any of the symptoms listed below. Persons with symptoms should receive a chest x-ray, regardless of TB skin test or Interferon-Gamma Release Assay (IGRA) test result.

Clients or employees with a documented history of a positive tuberculin skin or IGRA test result should not be re-tested or receive annual x-rays. In lieu of annual chest x-rays, symptom screening should be performed annually to determine the presence of TB disease. Any person with symptoms should receive a chest x-ray and be evaluated for TB disease.

If a client answers yes to any of the following questions, please document the approximate date each symptom started.

- | | | | |
|--|----|-----|------------|
| 1. Productive cough for 2 weeks or more | No | Yes | Date _____ |
| 2. Persistent weight loss without dieting | No | Yes | Date _____ |
| 3. Persistent fever above 100 degrees F | No | Yes | Date _____ |
| 4. Night sweats | No | Yes | Date _____ |
| 5. Loss of appetite | No | Yes | Date _____ |
| 6. Swollen glands in neck or elsewhere | No | Yes | Date _____ |
| 7. Coughing up blood (hemoptysis) | No | Yes | Date _____ |
| 8. Shortness of breath | No | Yes | Date _____ |
| 9. Chest pain | No | Yes | Date _____ |
| 10. Headaches, neck stiffness,
and/or disorientation or confusion | No | Yes | Date _____ |

Notes: _____

Chest x-ray referral: Date: _____ Referred to: _____

Sputum collection referral: Date: _____ Referred to: _____

Medical evaluation referral: Date: _____ Referred to: _____

Clients that have symptoms consistent with TB should be placed in isolation under negative air pressure until a diagnosis of tuberculosis can be ruled out. Employees with symptoms consistent with TB should be placed on a work stop precaution until a TB diagnosis is ruled out.