Pediatric TB Symptom Review Form

Tuberculosis Control Program
123 West Manchester Boulevard Room 228 | Inglewood, CA 90301Phone: (213) 745-0800 | Fax: (213) 749-0926

Date: _____
Name: _____
DOB / Age: _____
Sex: ☐ Male ☐ Female ☐ Other
Contact Information: _____

The purpose of this form is to help identify children who require evaluation for active TB. The presence of any of the following symptoms without an alternative explanation should trigger evaluation:

Symptoms	YES	NO
1. Cough for more than 2-3 weeks		
2. Weight loss		
3. Night sweats that soak through sheets or clothing		
4. Coughing up blood		
5. Excessive tiredness		
6. Fevers		
7. Swollen lymph nodes		

If the individual demonstrates any TB symptoms on the review, complete the CMR report (http://ph.lacounty.gov/tb/Forms/cmr%20form.pdf) and fax to (213) 749-0926.

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Licensed clinical professional (MD, DO, NP, PA, RN, LVN)