

Tuberculosis Risk Questionnaire

Name and surname of the child:	Birth no. (insuree no):
Birth date of the child: (if birth no. not available)	Insurance comp. code:
Address of permanent residence of the patient: (or another address)	

Part I – filled by the legal representative of the child

1. One or both parents of the child or a sibling of the child or a member of the household where the child lives, had/has an active tuberculosis:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No / not known
2. The child, one or both parents of the child or a sibling of the child or a member of the household where the child lives, is born or continuously stays/resides outside the Czech Republic for more than three months:	
<input type="checkbox"/> Yes; state the state (list all the states)	<input type="checkbox"/> No / not known
3. The child has been in contact with a tuberculosis patient:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No / not known
4. Persons the child has been in contact with have undergone examinations for TB:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No / not known
Name and surname of a legal representative of the child	Name of the general practitioner (GP) for pediatric patients
Telephone number of legal representative of the child	Telephone number of the GP for pediatric patients
Date	Signature of a legal representative

II. část – vyplňuje lékař

1. Dítě má indikaci k očkování proti tuberkulóze podle přílohy č. 2 k vyhlášce č. 537/2006 Sb., o očkování proti infekčním nemocem, ve znění pozdějších předpisů:	
<input type="checkbox"/> Ano	<input type="checkbox"/> Ne
Datum:	Jmenovka podpis lékaře: