TUBERCULOSIS RISK ASSESSMENT FORM

Physician/ Health Provider:	Phone:	Date:

Name: _____ **Date of Birth**: _____/_____/_____

Address: _____ **City**: _____ **State**: _____ **County**: _____

Phone: _____ **Race:** ❒White ❒Black ❒Asian ❒Am. Indian/Nat. Alaskan ❒Other _____

Sex: ❒Male ❒Female **Hispanic:** ❒No ❒Yes **US Born**: ❒Yes ❒No **If no, US Date of Arrival**: ____/____/____

TB RISK FACTORS AND MEDICAL CONDITIONS:

1. Have you ever had a positive skin or blood test?	❒Yes ❒No	If yes, when: _____
2. Have you had any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss, or fatigue)?	❒Yes ❒No	If yes, name of symptoms: _____
3. Have you ever been told you have an abnormal chest X-Ray?	❒Yes ❒No	If yes, when: _____
4. In the last 2 years, have you lived with or spent time with someone who has been sick with TB?	❒Yes ❒No	
5. Were you born in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean, or the Middle East?	❒Yes ❒No	If yes, in what country were you born: _____
6. Have you lived or traveled in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean, or the Middle East for more than one month?	❒Yes ❒No	If yes, in what country did you trave to: _____
7. Have any members of your household come to the United States from another country?	❒Yes ❒No	If yes, name of country: _____
8. Have you been exposed to a person who: • Is currently in jail or who has been in jail in the past 5 years? • Has HIV? • Is homeless? • Lives in a group home? • Uses illegal drugs? • Is a migrant farm worker?	❒Yes ❒No	If yes, name the risk factors you have been exposed to: _____ _____
9. Do you have any of the following medical conditions? • Diabetes • Chronic kidney failure with dialysis • Cancer of the neck, head, or lungs • Cancer of the blood or lymph system • HIV/AIDS • Autoimmune disease or immunosuppressive condition • Intestinal bypass or gastrectomy	❒Yes ❒No	
10. Have you ever been in jail or prison?	❒Yes ❒No	If yes, where: _____
11. Have you ever been an injection drug user?	❒Yes ❒No	If yes, specify: _____
12. Have you had an organ transplant?	❒Yes ❒No	If yes, specify: _____
13. Have you been around a person sick with active TB disease?	❒Yes ❒No	If yes, when: _____
14. Have you ever worked in a lab that processed TB samples?	❒Yes ❒No	If yes, where: _____

If you answered NO to all of the above questions, you are not in a high-risk group and do not need a TB skin test.

If you answered YES to any of the above questions, you fall into a high-risk group and should have a TB skin test or other tests for TB.

MEDICAL INFORMATION:

Primary Reason for Evaluation: ❒Contact Investigation ❒Targeted Testing ❒Immigration Exam
❒Incidental Abnormal CXR/CT ❒Incidental Lab Result
❒Other: _____

Symptomatic: ❒No ❒Yes If Yes, ONSET date: _____/_____/_____

Symptoms: ❒Cough ❒Hemoptysis ❒Fever ❒Night Sweats ❒Weight Loss of _____lbs
❒Other: _____

Previous BCG Vaccine: ❒No ❒Yes

Tuberculin Skin Test (TST/Mantoux/PPD) **Date Given: _____/_____/_____** **Date Read: _____/_____/_____**	**Induration: _____ mm** **Impression:** ❒Negative ❒Positive
Interferon Gamma Release Assay (IGRA) **Date: _____/_____/_____**	**Impression:** ❒Negative ❒Positive ❒Indeterminate
Chest X-ray (required with positive TST or IGRA) **Date: _____/_____/_____**	**Impression:** ❒Normal ❒Abnormal findings
❒ **LTBI treatment** (Rx and start date): Rx:_____ Date: _____/_____/_____ ❒ **Contraindications to INH or rifampin for LTBI**	❒ **Prior TB/LTBI treatment** (Rx and duration): Rx: _____ _____mm ❒ **Offered but refused LTBI treatment**

ADDITIONAL COMMENTS:

_____

_____

_____

RECOMMENDATIONS:

_____

_____

_____

Health Provider Signature: _____ **Date Completed: ____/____/____**