NAME	
ID #	
DOB	

Southeastern National Tuberculosis Center
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Risk Assessment for Tuberculosis

Reason for Visit (explain to the client the reason they are here (i.e., you are being seen in H&P and we do a TB screening on everyone).

Please specify: ☐ Intake ☐ Sick Call ☐ Clinic ☐ H&P ☐ Other (specify) Date:

History (ask the client and document responses here)

Previous Tuberculin Skin Test (TST)/Blood Test for TB (IGRA) ☐ **Documented (D)** ☐ **Verbal (V)**				☐ Yes	☐ No
If TST:	Location/ Facility:	Date:	Result: mm		
If IGRA:	Location/ Facility:	Date:	Result:		
Previous treatment for TB disease ☐ **Documented (D)** ☐ **Verbal (V)**				☐ Yes	☐ No
Location/ Facility:		Date:	Duration of treatment: months		
Medications:					
Previous treatment for LTBI ☐ **Documented (D)** ☐ **Verbal (V)**				☐ Yes	☐ No
Location/ Facility:		Date:	Duration of treatment: months		
TB medications:					
Follow-up Needed/Comments:				☐ Yes	☐ No
History of BCG ☐ **Documented (D)** ☐ **Verbal (V)**				☐ Yes	☐ No
Location/ Facility:		Date:	Date of last dose:		
If client has a history of TB treatment but not completed, refer to the clinic.					

Symptoms of TB disease

Do you have a cough lasting longer than three weeks?	☐ Yes	☐ No
Do you or have you had hoarseness lasting longer than three weeks?	☐ Yes	☐ No
Do you have bloody sputum or are you coughing up blood? (Hemoptysis)	☐ Yes	☐ No
Do you or have you had a fever that won't go away?	☐ Yes	☐ No
Do you or have you had chills that won't go away?	☐ Yes	☐ No
Do you have night sweats?	☐ Yes	☐ No
Have you had a loss in your appetite?	☐ Yes	☐ No
Have you had weight loss recently (greater than 20 #)?	☐ Yes	☐ No
Do you get tired easily? (Easily fatigued)	☐ Yes	☐ No
→ If symptoms exist, seek medical evaluation promptly. If cough, hoarseness or hemoptysis is present, isolate immediately in negative airborne infection isolation (AII) room.		

Risk Factors

Those incarcerated or working in correctional facilities are at increased risk for <u>becoming infected</u> with TB.
Below are risk factors for progression to <u>active disease</u>, if infected.

Higher Risk

Have you been around anyone with active TB? (Contact to TB case)	☐ Yes	☐ No
Have you ever been tested for HIV?	☐ Yes	☐ No
Was it negative or positive? ☐ Negative ☐ Positive If positive, date?		
Have you had unprotected sex? (At high-risk for HIV infection but unknown status)	☐ Yes	☐ No
Do you do IV drugs? (At high-risk for HIV infection but unknown status)	☐ Yes	☐ No
Have you ever had a chest x-ray recently? Changes on chest x-ray (consistent with prior TB)	☐ Yes	☐ No
What did the doctor tell you? ☐ Negative ☐ Positive What did he say?		
Have you ever had an organ transplant? (Organ transplant recipient)	☐ Yes	☐ No
Have you had steroids or prednisone for any length of time? (Other immunosuppression factors, e.g., receiving equivalent of ≥ 15 mg/d of prednisone for one month or longer)	☐ Yes	☐ No

Increased Risk

Have you had a TST in the past? (Increased risk: Documented TST conversion within the last two years)	☐ Yes	☐ No
When did it become positive?	☐ Yes	☐ No
Were you born in the U.S.? (Recent (within the last five years) immigrant from high TB-prevalent [endemic] country)	☐ Yes	☐ No
If not, what country were you born in? Country:		
How long have you been in the U.S.? Date:		
Are you taking or planning on taking medication for arthritis? (TNF blocker medications for Rheumatoid Arthritis [e.g., Remicade/Infliximab, Enbrel, Humira])	☐ Yes	☐ No
Do you use non-injection drugs?	☐ Yes	☐ No
Have you ever worked in a lab? (Mycobacteriology laboratory personnel especially)	☐ Yes	☐ No
Have you ever been diagnosed with:		
Silicosis	☐ Yes	☐ No
Diabetes mellitus	☐ Yes	☐ No
Chronic renal failure	☐ Yes	☐ No
Cancer of the head, neck, or lung	☐ Yes	☐ No
Leukemias/lymphomas	☐ Yes	☐ No
Low body weight (≥ 10% of below ideal body weight)	☐ Yes	☐ No
Have you ever had gastric surgery or surgery on your stomach? (Gastrectomy/jejunoileal bypass)	☐ Yes	☐ No
Do you see a doctor regularly? (Socio-economic predictors of exposure based on local morbidity data)	☐ Yes	☐ No
If no, when was the last time? Date:		

Recommendations and Results (Completed by the nurse – do not ask the patient)

TST administered: ☐ Yes ☐ No Site: ☐ LFA ☐ RFA ☐ Other (specify) Manufacturer: ☐ Tubersol ☐ Aplisol Lot No:		Dates:
TST read: ☐ Yes ☐ No Results: mm		
Comments:		
IGRA done: ☐ Yes ☐ No ☐ QFT-TB-GIT ☐ T-Spot	Results: ☐ Positive ☐ Negative ☐ Indeterminate	
Documented converter within the last two years? ☐ Yes ☐ No		
If positive, chest x-ray done: ☐ Yes ☐ No		
Results:		
Candidate for treatment? ☐ Yes ☐ No If yes, check one: ☐ LTBI ☐ Active TB		

Placed on medication?	☐ INH	☐ Rifampin	☐ Pyrazinamide	☐ Ethambutol	☐ INH & Rifapentine
Other:					
Comments:					

Disposition:

If 10mm or more, obtain chest x-ray and refer to the clinic
If 5mm – 9mm, obtain chest x-ray
If less than 5mm, no further action

Education

Education for TB/LTBI provided.	☐ Yes	☐ No
Client advised that if TST/IGRA is positive, he/she will be evaluated for treatment.	☐ Yes	☐ No

I understand the information as provided and will follow-up with my healthcare provider as recommended.

Signature	*Date*
Signature of Healthcare Worker	*Printed Name of Healthcare Worker*
Title of Healthcare Worker	*Date*

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