Adult Tuberculosis (TB) Risk Assessment Questionnaire[1]

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)

To be administered by a licensed health care provider (physician, physician assistant, nurse, nurse practitioner)

Name: _____

Date of Birth: _____ Date of Risk Assessment: _____

History of positive TB test or TB disease Yes □ No □

If yes, a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire.

If there is a "Yes" response to any of the questions #1-5 below, then a tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) should be performed. A positive test should be followed by a chest x-ray, and if normal, treatment for TB infection considered.

Risk Factors	
1. One or more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue) Note: A chest x-ray and/or sputum examination may be necessary to rule out infectious TB.[2]	Yes □ No □
2. Close contact with someone with infectious TB disease	Yes □ No □
3. Foreign-born person (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes □ No □
4. Traveler to high TB-prevalence country for more than 1 month (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes □ No □
5. Current or former resident or employee of correctional facility, long-term care facility, hospital, or homeless shelter	Yes □ No □

Once a person has a documented positive test for TB infection that has been followed by an x-ray that was deemed free of infectious TB, the TB risk assessment is no longer required.

[1] Adapted from a form developed by Minnesota Department of Health TB Prevention and Control Program and Centers for Disease Control and Prevention.

[2] Centers for Disease Control and Prevention (CDC). *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers*. 2013. (http://www.cdc.gov/tb/publications/LTBI/default.htm)

3/13/2014

California Tuberculosis Controllers Association

ADULT TUBERCULOSIS (TB) RISK ASSESSMENT QUESTIONNAIRE

CERTIFICATE OF COMPLETION

(To be signed by health care provider completing the risk assessment and/or examination)

Name: _____

Date of Birth: _____ **Date of Risk Assessment:** _____

The above named patient has submitted to a tuberculosis risk assessment, and if tuberculosis risk factors were identified has been examined and determined to be free of infectious tuberculosis.

_____

Health Care Provider Signature **Date**

_____

Health Care Provider Name **Title**

_____

Office Address: Street **City** **State** **Zip Code**

_____

Telephone **Fax**