

Adult Tuberculosis (TB) Risk Assessment Questionnaire¹

(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	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
2. Close contact with someone with infectious TB disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Foreign-born person (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
5. Current or former resident or employee of correctional facility, long-term care facility, hospital, or homeless shelter	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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>)

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 _____