



# TUBERCULOSIS RISK ASSESSMENT AND EVALUATION

**(THIS FORM IS TO BE COMPLETED AND RETURNED TO STUDENT HEALTH SERVICES PRIOR TO ATTENDING ANY CLASSES.)**

PLEASE PRINT

NAME \_\_\_\_\_ /DATE \_\_\_\_\_  
LAST FIRST

LAST 4 DIGITS OF SOCIAL NUMBER \_\_\_\_\_ /DATE OF BIRTH \_\_\_\_\_

### RISK FACTORS

Recent contact with someone with infectious tuberculosis disease	Yes	No
Foreign born or travel to/or in countries with high prevalence of tuberculosis (e.g. Africa, Asia, Eastern Europe, Central or South America)	Yes	No
Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	Yes	No
Has HIV/AIDS	Yes	No
Organ transplant recipient	Yes	No
Immunosuppressed (equivalent of >15 mg of prednisone for > 1 month or TNF-a antagonist)	Yes	No
History of illicit drug use	Yes	No
***Resident, employee, or volunteer in a high-risk congregate setting (e.g. correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)	Yes	No
****Medical condition associated with increased risk of progressing to TB disease if infected (e.g. diabetes mellitus, silicosis, head/neck/lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, intestinal by-pass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e. 10% or more below ideal weight for the given population)	Yes	No

### SYMPTOMS OF TB (mark all that apply)

<input type="checkbox"/> Productive cough	Date of onset ____/____/____
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Fever
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Lymphadenopathy Hematuria	<input type="checkbox"/> Hemopytisis

### Tuberculin Skin Test (TST)

(TST should be records as actual millimeters (mm) of induration, transvers diameter ---- if no induration, write "0".

The TST interpretation should be based on mm of induration as well as risk factors.)

### Risk Criteria Used in Establishing Significance of PPD Skin test reaction

➤ 5mm is positive if:	➤ 10 mm is positive if:	➤ 15 mm is positive if:
HIV infection close contact to TB case Fibrotic changes on Chest x-ray consistent with old TB Organ transplant Other immunosuppressed patients	Recent arrivals from high prevalence countries Injection drug users Residents and employees of high risk congregate settings*** <b>(see above)</b> Myobacteriology lab personnel Persons with clinical conditions that make them high risk **** <b>(see above)</b>	NO known risk factors for TB disease

DATE GIVEN: \_\_\_\_/\_\_\_\_/\_\_\_\_ IMPLANT SITE: \_\_\_\_\_ TIME: \_\_\_\_\_ GIVEN BY: \_\_\_\_\_

DATE READ: \_\_\_\_/\_\_\_\_/\_\_\_\_ READ BY: \_\_\_\_\_ TIME: \_\_\_\_\_ CLINIC NAME \_\_\_\_\_

RESULT: \_\_\_\_\_ MM OF INDURATION INTERPRETATION: negative \_\_\_\_\_ positive \_\_\_\_\_

----- OR -----

### Interferon Gamma Release Assay (IGRA)

DATE OBTAINED \_\_\_\_/\_\_\_\_/\_\_\_\_ SPECIFY METHOD: \_\_\_ QFT-G \_\_\_ GFT-GIT OTHER \_\_\_\_\_

RESULT: negative \_\_\_\_\_ positive \_\_\_\_\_ intermediate \_\_\_\_\_

**IF EITHER ABOVE TEST POSITIVE OR YOU HAVE HAD PREVIOUS REACTION TO TB TESTING, OBTAIN A CHEST X-RAY.**

DATE OF CHEST X-RAY: \_\_\_\_/\_\_\_\_/\_\_\_\_ RESULT: normal \_\_\_\_\_ abnormal \_\_\_\_\_

(and/or attach copy of x-ray report)

**IF ABNORMAL RESULTS ON CXR FURTHER EVALUATION AND TREATMENT IS REQUIRED.**

The above individual has received all necessary evaluations and treatments as required and are cleared to attend classes.

SIGNATURE OF HEALTH CARE PROVIDER \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

PRACTICE SITE: \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_