BARTON COMMUNITY COLLEGE

TUBERCULOSIS RISK ASSESSMENT AND EVALUATION

THIS FORM IS TO BE COMPLETED AND RETURNED TO STUDENT HEALTH SERVICES PRIOR TO ATTENDING ANY CLASSES *(ALL TESTING MUST BE COMPLETED IN THE UNITED STATES)*

PLEASE PRINT

NAME _____, _____ **DATE OF BIRTH**_____ **STUDENT ID** _____

Last First mm/dd/yyyy

Recent contact with someone with infectious tuberculosis disease?	Yes	No
Foreign-Born or traveled and spent ≥ 3 months in a country with a 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 >15mg prednisone for > 1 month or TNF-a antagonist?	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

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS OF TB? (mark all that apply)

___ Productive Cough	___Fever
___ Weight Loss (unintentional)	___ Fatigue
___ Night Sweats	___ Shortness of Breath
___ Chest Pain	___ Hemoptysis (coughing up blood)
___ Lymphadenopathy (swollen lymph nodes)	___ Hematuria (blood in urine)

Tuberculin Skin Test (TST)

Record induration in millimeters (mm). The 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:	➢ 10mm is positive if:	➢ 15mm 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* -Mycobacteriology lab personnel -Persons with clinical conditions that make them high risk**	-NO known risk factors for TB

DATE GIVEN: ____/____/_____ TIME: _____ SITE: _____ GIVEN BY: _____

DATE READ: ____/____/_____ TIME: _____ READ BY: _____ CLINIC NAME: _____

RESULT: _____ MM OF INDURATION INTERPRETATION: Negative _____

Positive _____ (Obtain Chest X-ray* and Lab Testing)**

********OR********

Interferon Gamma Release Assay (IGRA) - QuantiFERON (TB Gold)

DATE OBTAINED: ____/____/_____ RESULT: Negative _____ Positive _____ (Obtain Chest X-Ray*)**

-IF THE TB SKIN TEST ABOVE IS POSITIVE, OBTAIN A CHEST X-RAY* AND QUANTIFERON LAB TESTING**

-IF YOU HAVE HAD A PREVIOUS REACTION TO TB TESTING, OBTAIN A CHEST X-RAY*

ATTACH PERTAINING CHEST X-RAY AND LAB RESULTS

*****IF CHEST X-RAY IS ABNORMAL, 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 HEALTHCARE PROVIDER: _____ DATE: ____/____/_____

PRACTICE SITE: _____ PHONE NUMBER: _____