

Clay County Health Department

Tuberculosis (TB) Risk Assessment Screening Form

Patient Last Name: _____ First: _____
 Address: _____ City _____ State _____ Zip Code _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Birthdate: ____/____/____ Sex: M ____ F ____ Last 4 Digits of Social Security Number: _____ Ethnicity: _____ Race: _____
COUNTRY OF BIRTH: _____ If applicable, date of US arrival: _____
 History of BCG vaccine: Y ____ (year received: _____) N ____ If female, is patient pregnant: Y ____ N ____ Allergies: _____
REASON FOR TB SCREENING/TESTING
 Work Requirement Yes ____ No ____ Name of Employer/Location: _____
 School Requirement Yes ____ No ____ Name of School/Location: _____
 Other (please provide reason for testing) _____
Previous (Last) Tuberculin Skin Test Yes ____ No ____ If Yes, Date of test ____/____/____ Positive ____ Negative ____

<p>HAVE YOU EVER BEEN EMPLOYED IN ANY OF THE FOLLOWING:</p> <p>Health Care Worker Yes ____ No ____ Homeless Shelter Yes ____ No ____ Nursing Home Yes ____ No ____ Correctional Facility Yes ____ No ____ Long Term Residential Facility Yes ____ No ____</p>	<p>RISK FACTORS CHECK ALL BOXES BELOW THAT APPLY:</p> <p>Been a close contact to someone with active TB Yes ____ No ____ Had a positive TB test Yes ____ No ____ Visited another country for 3 months or longer Yes ____ No ____ Lived in another country Yes ____ No ____ Lived in a homeless shelter Yes ____ No ____ Lived in a nursing home Yes ____ No ____ Been an inmate in a correction facility Yes ____ No ____ Lived in a long term residential facility Yes ____ No ____ Used IV drugs Yes ____ No ____ Used alcohol in excess (more than 1 drink per day) Yes ____ No ____</p>
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<p>DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?</p> <p>Cough (longer than 3 weeks) Yes ____ No ____ Fever Yes ____ No ____ Coughing up blood Yes ____ No ____ Loss of weight Yes ____ No ____ Loss of appetite Yes ____ No ____ Night Sweats Yes ____ No ____ Fatigue Yes ____ No ____</p>	<p>MEDICAL RISK FACTORS CHECK ALL BOXES BELOW THAT APPLY</p> <p>Taken more than 15 mg. per day of prednisone Yes ____ No ____ Taken medicine for rheumatoid arthritis Yes ____ No ____ Known risk for HIV infection Yes ____ No ____ Diabetes Yes ____ No ____ Silicosis Yes ____ No ____ Cancer of the head and neck Yes ____ No ____ Leukemia Yes ____ No ____ Renal (kidney) disease Yes ____ No ____ Intestinal bypass Yes ____ No ____ Gastrectomy Yes ____ No ____ Impaired immune system Yes ____ No ____</p>
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Form Completed by _____ Relationship to Patient _____

THIS SECTION IS TO BE COMPLETED BY MEDICAL PERSONNEL

Notes: _____

Findings:

Previous Treatment for LTBI and/or TB disease	Yes ____ No ____
Risk factors for TB infection identified	Yes ____ No ____
Risk(s) for infection and/or progression to disease	Yes ____ No ____
Possible TB suspect	Yes ____ No ____
Previous positive TST, no prior treatment	Yes ____ No ____

Action(s):
 Issued screening letter ____ Referred for CXR ____ Referred for medical evaluation ____ Administered PPD ____

Signature of Screener: _____ Date of Screening: ____/____/____ Time: _____
 Version: 01/20/2009