Kanawha-Charleston 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_____

HAVE YOU EVER BEEN EMPLOYED IN ANY OF OF THE FOLLOWING:

Health Care Worker	Yes____	No____
Homeless Shelter	Yes____	No____
Nursing Home	Yes____	No____
Correctional Facility	Yes____	No____
Long Term Residential Facility	Yes____	No____

RISK FACTORS

CHECK ALL BOXES BELOW THAT APPLY:

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____

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

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____

MEDICAL RISK FACTORS

CHECK ALL BOXES BELOW THAT APPLY

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____

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