

## Adult Tuberculosis (TB) Risk Assessment Questionnaire

*Must be administered by a licensed health care provider (physician, physician assistant, nurse, nurse practitioner)*

Employee Name: \_\_\_\_\_ Employee ID Number: \_\_\_\_\_

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Adult Tuberculosis (TB) Risk Assessment Questionnaire Certificate of Completion

*(Must be signed by the health care provider completing the risk assessment and/or examination)*

*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 Physician License Number

\_\_\_\_\_  
Office Address: Street City State Zip Code

\_\_\_\_\_  
Telephone Fax