Adult Tuberculosis (TB) Risk Assessment Questionnaire

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

Employee/Volunteer Name:_____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 the previous 6 months) should be performed.

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