Adult Tuberculosis (TB) Risk Assessment Questionnaire[1]

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)

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

Name: _____ Date of Risk Assessment: _____

Date of Birth: _____

History of positive TB test or TB disease Yes ☐ No ☐ Date of X-Ray: _____

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.[2]	Yes ☐ No ☐
2. Close contact with someone with infectious TB disease	Yes ☐ No ☐
3. Birth in high TB-prevalence country (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe)	Yes ☐ No ☐
4. Travel 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 residence or work in a correctional facility, long-term care facility, hospital, or homeless shelter	Yes ☐ No ☐

[1] Adapted from a form developed by Minnesota Department of Health TB Prevention and Control Program and Centers for Disease Control and Prevention.

[2] Centers for Disease Control and Prevention (CDC). *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers*. 2013. (http://www.cdc.gov/tb/publications/LTBI/default.htm)

TCB-01 (12/14) Effective January 1, 2015

**TO BE COMPLETED WHEN EMPLOYEE REFERRED FOR FOLLOW UP

Date Referred: _____ School Nurse: _____

ADULT TUBERCULOSIS (TB) RISK ASSESSMENT QUESTIONNAIRE

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)

CERTIFICATE OF COMPLETION

To be signed by the licensed health care provider completing the risk assessment and/or examination

Name: _____ **Date:** _____

Date of Birth: _____

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

_____

Health Care Provider Signature

_____

Please Print Health Care Provider Name **Title**

_____

Office Address: Street **City** **State** **Zip Code**

_____

Telephone **Fax**