Adult TB Risk Assessment and Screening Form
(For Patient Record)

Name: _____ DOB: _____ Date: _____

TB Risk Assessment	Yes	No
1) Were you born in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East? In what country were you born? _____	☐	☐
2) In the past 5 years, have you lived or traveled in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East for more than one month?	☐	☐
3) In the last 2 years, have you lived with or spent time with someone who has been sick with TB?	☐	☐
4) Do you have (or have you had) any of these medical conditions? Diabetes — Kidney disease HIV infection — Colitis Cancer — Stomach or intestine surgery Rheumatoid arthritis	☐	☐
5) Are you taking any medications that your doctor said could weaken your immune system or increase your risk for infections?	☐	☐
6) In the past 1 year, have you injected drugs that your doctor did not prescribe?	☐	☐
7) Have you ever lived or worked in a prison, jail, homeless shelter or long-term care facility? (example: nursing home, substance abuse treatment, rehabilitation facility)	☐	☐

Symptom Screening – At this time, do you have any of these symptoms?	Yes	No
1) Coughing for more than 2-3 weeks?	☐	☐
2) Coughing up blood?	☐	☐
3) Weight loss of more than 10 pounds for no known reason?	☐	☐
4) Fever of 100°F (or 38°C) for over 2 weeks?	☐	☐
5) Unusual or heavy sweating at night?	☐	☐
6) Unusual weakness or extreme fatigue?	☐	☐

If you answer "yes" to any of the questions above, you may be at increased risk for TB infection. Please give this form to your medical provider.

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Name: _____ DOB: _____ Date: _____

Medical Record Number: _____

TB History and Triage (to be completed by medical provider)

TB History	Yes	No
1) Has the person had a TB test (skin test or blood test)? TB test result: ☐ Positive ☐ Negative ☐ Unknown TB test date: _____ (MM/YY) Where: _____ (facility)	☐	☐
2) Did the person get a chest x-ray after the TB test? X-ray result: _____ X-ray date: _____ (MM/YY)	☐	☐
3) Did the person take medication for TB infection?	☐	☐
4) Does the person remember being sick with TB? If yes, when: _____ (MM/YY) Where: Country _____ State: _____	☐	☐

Triage Plan	
☐	**Person has TB risk and has one or more TB symptoms:** Refer the person for **prompt clinical evaluation** including a chest x-ray to rule out active TB
☐	**Person has TB risk, no symptoms and has no history of previous positive TB test:** Test for TB infection or refer for testing and evaluation
☐	**Person has a history of previous positive TB test, but has no evidence of treatment:** Refer for TB evaluation and treatment

TB Test Documentation

Tuberculin Skin Test (TST) plant date: _____ (MM/DD/YY) / TST read date: _____ (MM/DD/YY)

TST Result: _____ *(Millimeters of Induration)* / TST Interpretation: ☐ Positive* ☐ Negative ☐ Unknown

Interferon-Gamma Release Assay (IGRA) performed _____ *(*MM/DD/YY*)*

IGRA Interpretation: ☐ Positive* ☐ Negative ☐ Indeterminate/Borderline (requires repeat test)

*** Report all persons with positive TB test to the Massachusetts Department of Public Health (DPH) http://www.mass.gov/eohhs/gov/departments/dph/programs/id/isis/case-report-forms.html**

Medical Provider Signature: _____ **Date:** _____

Massachusetts Department of Public Health / Bureau of Infectious Disease /
Division of Global Populations and Infectious Disease Prevention
November 2013

Adult TB Risk Assessment and Screening Form
Instructions to Medical Providers

The purpose of the TB risk assessment and screening form is to identify persons with **increased risk for TB** who may require further testing and evaluation. Persons born in countries where TB is common are at increased risk for TB (especially, but not limited to those who arrived in the last 5 years).

The **TB Self-Assessment of TB Risk section** can be completed by the patient/client/guardian alone or with provider's assistance. The provider should review the information and discuss TB risks, symptoms, previous TB testing and treatment with the patient/client.

If the person with TB risk describes or exhibits symptoms suggestive of possible active TB:

- Isolate the patient/client immediately (if possible) and have the patient/client wear a mask.
- Refer the patient/client for prompt clinical evaluation including a chest x-ray. Ensure that the patient/client wears a mask during transport to the provider.
- Consult the Massachusetts Department of Public Health/Bureau of Infectious Disease/ Division of Global Populations and Infectious Disease Prevention at 617-983-6970.

If the person has a history of TB or TB risk, but has no symptoms suggestive of TB:

- Educate the patient/client about signs and symptoms of TB and should such symptoms develop, instruct them to seek medical follow-up.
- Consider testing the patient/client for TB infection or refer to primary care provider.
- Consult the Massachusetts Department of Public Health/Bureau of Infectious Disease, Division of Global Populations and Infectious Disease Prevention at 617-983-6970, if needed.

Resources

Information about TB evaluation, testing and treatment can be found at http://www.cdc.gov/tb/ and http://www.mass.gov/dph/cdc/tb

Guideline on the use of Interferon-Gamma Release Assay can be found at http://www.mass.gov/eohhs/gov/departments/dph/programs/id/tb/testing-screening/

Cases of suspect active or confirmed cases of active TB and TB infection are reportable to the Massachusetts Department of Public Health per Chapter 105, Code of Massachusetts Regulations (CMR), Section 300.000: Reportable Diseases, Surveillance, and Isolation & Quarantine Requirements) http://www.mass.gov/eohhs/gov/departments/dph/programs/id/epidemiology/rdiq/reporting-diseases-and-surveillance-information.html

DPH-supported TB clinics http://www.mass.gov/eohhs/docs/dph/cdc/tb/regional-clinic-list.pdf