Tuberculosis Risk Assessment - Tuberculin Screening Test Form

Reason for Risk Assessment_____

Client's Last Name _____**First Name** _____**DOB:** _____**Age:**_____
Interpreter needed No ☐ **Yes** ☐
Language _____**Language Line , Name & #**_____

Airborne Infection Isolation Triage
☐No reported symptoms at check-in ☐ Isolated to negative pressure room ☐N-95 mask used by Staff

1. **Country of Birth**
   ☐ USA
   ☐ Other_____
2. **If not born in the USA:**
   When did the client arrive in the USA?
   Month _____ Year _____
   When did you receive your last BCG?_____
3. **Has the client lived or traveled outside the U.S.A.?**
   ☐ No ☐ Yes
   If YES, Where/When/How long:_____
4. **Date of last TST** _____
   City and State_____
   Documented ☐No ☐ Yes
5. **Has the client had a chest x-ray in last five years?**
   ☐**No**
   ☐**Yes** Year_____ Where_____
6. **Been in close contact with a person sick with TB?**
   ☐No ☐Yes
7. **Has the client ever been treated for TB?**
   ☐No
   ☐Not sure
   ☐Active TB ☐LTBI
   Where: _____
   Year _____Meds_____
   How Long? _____ Describe Tx _____
8. **Does the client <u>currently</u> have any of these conditions:**
   ☐ Diabetes
   ☐ Hepatitis/Liver problems
   ☐ Immune system disorder
   ☐ Steroids/ Immunosuppressants for > than 2 weeks
   ☐ Organ transplant, Gastrectomy/jejunoileal bypass
   ☐ Silicosis or lung disease from mining/sand blasting
   ☐ HIV infection/AIDS
   ☐ In the last six weeks, had any live virus vaccines?
   ☐ Chronic kidney failure/dialysis
   ☐ Rheumatoid arthritis
   ☐ **NONE**
9. **Current Medications**:_____
   _____
   _____

Notes related to assessment:
_____
_____
_____
_____
_____
_____
_____
Results: ____Reason for TST:_____
_____
_____
_____
_____
Results: ____Reason for CXR:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
Specify: _____
Specify: _____
_____
_____
_____
Specify: _____
_____
_____
_____
_____
_____
_____

10. Does the client have the following risk factors?

- ☐ Ever been homeless or lived/worked in a shelter
- ☐ Lived/worked in a nursing home
- ☐ Ever been an inmate or worked in a jail/prison
- ☐ Ever been a healthcare worker
- ☐ Alcohol use: ☐ none ☐ occasional ☐ 1-7 per week ☐ >7 per week
- ☐ Any recreational drug use: _____
- ☐ Smokes? ☐ No ☐ Hx _____ _____Cigarettes/pack/day/week x _____years
- ☐ Ever consumed unpasturized milk products
- ☐ NONE

Comments:_____

_____

_____

11. a Does the client have any of the following symptoms?

- ☐ Cough > three weeks ☐ Fevers
- ☐ Night Sweats ☐ Fatigue
- ☐ Loss of Appetite ☐ Other_____
- ☐ Loss of Weight Usual wt _____Today _____
- ☐ NONE

Comments:_____

_____

_____

_____

12. Females:

Is the client pregnant? No ☐ Yes ☐ EDC_____

Plan to breastfeed? No ☐ Yes ☐

I agree with the above information and consent to TB skin testing and any treatment and care as prescribed by the Tuberculosis Prevention and Control Program physicians.

Client Signature:_____ Date: _____

(Parent/Guardian for minor)

The above assessment completed by:

Nurse _____Date: _____ Interpreter _____Date: _____

Signature **Signature**

	DATE									
Sputum	**Given/ received**									
Initials										

	Test Placed						**Test Read / Resulted**				
TEST	DATE	TIME	Dose/Route 0.1cc intradermal	PPD Solution Lot #	Exp. Date	Site	DATE	TIME	SIZE mm	Result and Interpretation	Initials
TST			0.1cc								
TST			0.1cc								
IGRA			n/a								

NOTE: If active TB is suspected do CXR – do not wait for TST result, may be false negative

Based on induration and above history the TST is ☐ Negative ☐ Positive

CXR recommended? No ☐ Yes ☐ Date _____

MD Clinic Date _____Med Start Date _____Time _____

Reason Refused Rx:

- ☐ Inadequate Income ☐ Leaving area ☐ Lost to follow-up
- ☐ Personal preference ☐ Previous Treatment ☐ Uncooperative

TB education/literature given ☐

Release of Information signed ☐ No ☐ Yes

☐ Card given Date:_____ Initials _____

Nurse initials/signatures Interpreter initials/signatures

Last Name_____ First Name _____ DOB _____