Missouri Department of Health and Senior Services
Bureau of Communicable Disease Control and Prevention

Tuberculosis (TB) Risk Assessment Form

Patient's Name: _____ Date of Birth:_____ Date: _____

A. Please answer the following questions:	
Have you ever had a positive Mantoux tuberculin skin test (TST)?	☐Yes ☐ No
Have you ever been vaccinated with BCG?	☐Yes ☐ No
Have you ever had a positive Interferon Gamma Release Assay (IGRA) test?	☐Yes ☐ No

B. <u>TB Risk Assessment</u> - Persons with any of the following are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

Have you ever had close contact with anyone who was sick with tuberculosis (TB)?	☐Yes ☐ No
Have you ever traveled to/in one or more of the countries listed below? (**If yes,please CHECK the country/ies**)	☐Yes ☐ No
Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? (**If yes, please CIRCLE the country**)	☐Yes ☐ No

Afghanistan	Chad	Guinea-Bissau	Mali	Peru	Tanzania-UR
Algeria	China	Guyana	Marshall Islands	Philippines	Thailand
Angola	Colombia	Haiti	Mauritania	Poland	Timor-Leste
Anguilla	Comoros	Honduras	Mauritius	Portugal	Togo
Argentina	Congo	India	Mexico	Qatar	Tokelau
Armenia	Congo DR	Indonesia	Micronesia	Romania	Tonga
Azerbaijan	Cote d'Ivoire	Iran	Moldova-Rep.	Russian Federation	Tunisia
Bahamas	Croatia	Iraq	Mongolia	Rwanda	Turkey
Bahrain	Djibouti	Japan	Montenegro	St. Vincent &	Turkmenistan
Bangladesh	Dominican Republic	Kazakhstan	Morocco	The Grenadines	Tuvalu
Belarus	Ecuador	Kenya	Mozambique	Sao Tome & Principe	Uganda
Belize	Egypt	Kiribati	Myanmar	Saudi Arabia	Ukraine
Benin	El Salvador	Korea-DPR	Namibia	Senegal	Uruguay
Bhutan	Equatorial Guinea	Korea-Republic	Nauru	Seychelles	Uzbekistan
Bolivia	Eritrea	Kuwait	Nepal	Sierra Leone	Vanuatu
Bosnia & Herzegovina	Estonia	Kyrgyzstan	New Caledonia	Singapore	Venezuela
Botswana	Ethiopia	Lao PDR	Nicaragua	Solomon Islands	Viet Nam
Brazil	Fiji	Latvia	Niger	Somalia	Wallis & Futuna Islands
Brunei Darussalam	French Polynesia	Lesotho	Nigeria	South Africa	W. Bank & Gaza Strip
Bulgaria	Gabon	Liberia	Niue	Spain	Yemen
Burkina Faso	Gambia	Lithuania	N. Mariana Islands	Sri Lanka	Zambia
Burundi	Georgia	Macedonia-TFYR	Pakistan	Sudan	Zimbabwe
Cambodia	Ghana	Madagascar	Palau	Suriname	
Cameroon	Guam	Malawi	Panama	Syrian Arab Republic	
Cape Verde	Guatemala	Malaysia	Papua New Guinea	Swaziland	
Central African Rep.	Guinea	Maldives	Paraguay	Tajikistan	

Source: World Health Organization Global Tuberculosis Control, WHO Report 2006, Countries with Tuberculosis incidence rates of > 20 cases per 100,000 population. For future updates, refer to www.who.int/globalatlas/dataQuery/default.asp

Have you ever had an abnormal chest x-ray?	☐Yes ☐ No
Do you have HIV or AIDS?	☐Yes ☐ No
Are you an organ transplant recipient or donor?	☐Yes ☐ No
Are you immunosuppressed (taking an equivalent of > 15 mg/day of prednisone for ≥1 month, or currently taking prescription arthritis medication)?	☐Yes ☐ No
Are you a resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)?	☐Yes ☐ No
Do you have any medical conditions such as diabetes, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal)?	☐Yes ☐ No
Do you have you a cough lasting 3 weeks or longer, chest pain, weakness or fatigue, weight loss, chills, fever and/or night sweats? Are you coughing up blood or phlegm?	☐Yes ☐ No

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Patient please skip to Section D for required signature below.

C. Medical Evaluation (to be completed by Health Care Professional – if required)

Health Care Provider: If the answer to any of the TB Risk Assessment questions is YES, proceed with additional evaluation as needed.

1. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: _____ **Date Read:** _____
Result: _____ mm of induration ****Interpretation:** positive____ negative____
Date Given: _____ **Date Read:** _____
Result: _____ mm of induration ****Interpretation:** positive____ negative____

****Interpretation Guidelines**

>5 mm is positive:
- ☐ Recent close contacts of an individual with infectious TB
- ☐ Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- ☐ Organ transplant recipients
- ☐ Immunosuppressed persons: taking ≥ 15 mg/d of prednisone for ≥ 1 month; taking a TNF-α antagonist
- ☐ Persons with HIV/AIDS

>15 mm is positive:
- ☐ Persons with no known risk factors for TB disease

> 10 mm is positive:
- ☐ Persons born in a high prevalence country or who resided in one for a significant* amount of time
- ☐ History of illicit drug use
- ☐ Mycobacteriology laboratory personnel
- ☐ History of resident, worker or volunteer in high-risk congregate settings
- ☐ Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes
- ☐ Children < 4 years of age
- ☐ Children and adolescents exposed to adults in high-risk categories

2. Interferon Gamma Release Assay (IGRA)

Date Obtained: _____ (specify method) QFT-G QFT-GIT_____other_____
Result: Negative___ Positive___ Intermediate___
Date Obtained: _____ (specify method) QFT-G _____ QFT-GIT _____other_____
Result: Negative___ Positive___ Intermediate___

3. Chest X-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: _____ Result: normal____ abnormal_____

Comments: _____

4. Sputum Collection: Please collect three (3) consecutive sputum, one early morning and all must be at least eight (8) hours apart with a minimum of 2 milliliters/2ml per tube. Collect in containers provided by the Missouri Department of Health and Senior Services State Public Health Laboratory**. (Contact 573-751-3334 to order sputum containers.)**

1. **Date Obtained:** _____ **Result:** _____
2. **Date Obtained:** _____ **Result:** _____
3. **Date Obtained:** _____ **Result:** _____

If you have any questions regarding this form, please contact the Bureau of Communicable Disease Control and Prevention at (573) 751-6113.

D. Needed Signatures

_____ _____
Patient Signature (Required) Date:

I hereby certify that this application contains no misrepresentation or falsification and that the information given by me is true and complete to the best of my knowledge and belief.

_____ _____
Health Care Professional(Required) Date: