

TB Risk Assessment

Patient name: _____ Birth date: _____ Date: _____

SYMPTOMS:	YES	NO
Does the patient have any of the following symptoms? <i>(If you mark yes to any of the following symptom questions, please report the findings immediately to WV TBEP)</i>		
Cough for more than 2-3 weeks		
Hemoptysis (Coughing up blood)		
Fever		
Weight loss of more than 10 lbs. for no known reason		
Loss of appetite		
Night sweats		
Weakness or extreme fatigue		

RISK FACTORS:	YES	NO
Does the patient have any of the following risk factors? <i>(If you mark yes to any of the following risk factor questions, the patient is qualified for state funded testing)</i>		
Recent contact to someone with active TB		
Born in a country other than the U.S. If yes, what country? _____		
Visited another country and stayed for 2 months or more If yes, what country? _____		
Lived in another country If yes, what country? _____		
Ever lived or worked in a prison, jail or homeless shelter		
Ever worked in a healthcare facility (including long-term care) outside of West Virginia If yes, where? _____		
Ever injected drugs not prescribed by a doctor		
Currently or ever reported having any of the following medical conditions: <i>(please check all that apply)</i> <input type="checkbox"/> Diabetes <input type="checkbox"/> Stomach or intestinal surgery <input type="checkbox"/> HIV <input type="checkbox"/> Kidney disease <input type="checkbox"/> Chronic lung disease <input type="checkbox"/> Colitis <input type="checkbox"/> Cancer <input type="checkbox"/> Rheumatoid arthritis		
Currently taking or planning to take any medication that their doctor has said could weaken their immune system or increase their risk for infection* <i>(*Retesting should NOT be done on patients that already have a positive TB screening test if the patient is already on or getting ready to start immunosuppressive medications, these patients will require treatment regardless of any additional test results. We recommend treatment for all positive tests for these patients. Examples: chemotherapy, some rheumatoid arthritis medications, organ anti-rejection drugs, some medication to treat skin disorders, etc.)</i>		

Patient name: _____

TB HISTORY: Has the patient ever had any of the following?	YES	NO
Ever had a TB skin test: If yes: When _____ Where _____ Result _____		
Ever had a TB blood test: If yes: When _____ Where _____ Result _____		
Taken the BCG vaccine <i>(If you mark yes to this question the patient should only receive a TB blood test, DO NOT use PPD for testing)</i>		
Been treated with BCG for cancer <i>(If you mark yes to this question the patient should only receive a TB blood test, DO NOT use PPD for testing)</i>		
Ever taken medication for TB in the past		
Ever been diagnosed with TB in the past		

REASON FOR TESTING: What prompted testing today?	YES	NO
Employer requirement		
Educational institution requirement		
Doctor requires testing prior to starting a medication		
Other (please specify):		

FOR LHD OFFICE USE:

NURSE SIGNATURE: _____ DATE: _____

_____ State TST _____ State IGRA _____ Private TST _____ Private IGRA

_____ CXR _____ Diagnostic Clinic _____ Sputum X 3

_____ Letter Given _____ No Follow-Up Needed