TB Risk Assessment

Patient name: _____ **Birth date**: _____ **Date**: _____

SYMPTOMS: **Does the patient have any of the following symptoms?** (If you mark yes to any of the following symptom questions, please report the findings immediately **BY PHONE** to the county of residence or the WV TBEP)	**YES**	**NO**
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: **Does the patient have any of the following risk factors?** (If you mark yes to any of the following risk factor questions, the patient is qualified for state funded testing if retesting is not contraindicated, please refer to the Standard of Care Documents for more information)	**YES**	**NO**
Recent contact to someone with active TB (Retesting is **NOT** recommended for someone with known exposure to an active TB case)		
Born in a country other than the U.S. If yes, what country? _____		
Visited a high-risk country and stayed for 2 months or more If yes, what country? _____ (Please refer to the TB High Burden Country List)		
Lived in a high-risk country If yes, what country? _____ (Please refer to the TB High Burden Country list)		
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? _____ (This includes different Countries and States)		
Ever injected drugs not prescribed by a doctor		
Currently or ever reported having any of the following medical conditions: (please check all that apply) __ Diabetes __ Stomach or intestinal surgery __ HIV __ Kidney disease __ Chronic lung disease __ Colitis __ Cancer __ Rheumatoid arthritis (Please **DO NOT** retest if it is contraindicated, i.e. HIV positive, on a biologic medication, being put on a transplant list or ruling out active TB disease, etc**. We recommend treatment for all positive tests for these patients.** Please refer to the Standards of Care Documents for more information)		
Currently taking or planning to take any medication that their doctor has said could weaken their immune system or increase their risk for infection (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. **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.)		

Patient name: _____ **Birth date**: _____

TB HISTORY: **Has the patient ever had any of the following?**	**YES**	**NO**
Ever had a TB skin test prior to this referral to the Health Department: If yes: When _____ Where _____ Result _____		
Ever had a TB blood test prior to this referral to the Health Department: If yes: When _____ Where _____ Result _____		
Has taken the BCG vaccine (If you mark yes to this question the patient should only receive a TB blood test, **DO NOT** use PPD for testing)		
Has been treated with BCG for cancer (If you mark yes to this question the patient should only receive a TB blood test, **DO NOT** use PPD for testing)		
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		
Ruling out Active TB disease		
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