VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment
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Virginia Department of Health TB Control Program
TB Risk Assessment Form (TB 512)

Patient name (L,F,M): _____ DOB: _____ Race: _____ Sex: _____

Address: _____ Social Security Number: _____

City, State, ZIP: _____ Home/Work #: _____

Cell #: _____ Language: _____ Patient Pregnant: ___No ___Yes; If Yes, LMP: _____

Country of Origin: _____ Year arrived in US (if applicable): _____ Interpreter needed: ___No ___Yes

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I. Screen for TB Symptoms (Check all that apply)

_____None (Skip to Section II, "Screen for Infection Risk")

_____Cough for ≥ 3 weeks ➔ Productive: ___YES ___NO

_____Hemoptysis

_____Fever, unexplained

_____Unexplained weight loss

_____Poor appetite ⎤

_____Night sweats

_____Fatigue ⎦

Evaluate these symptoms in context

Pediatric Patients (≤ 6 years of age):
_____Wheezing
_____Failure to thrive
_____Decreased activity, playfulness and/or energy
_____Lymph node swelling
_____Personality changes

II. Screen for TB Infection Risk *(Check all that apply)*

Individuals with an increased risk for acquiring latent TB infection (LTBI) or for progression to active disease once infected should have a TST. Screening for persons with a history of LTBI should be individualized.

A. Assess Risk for Acquiring LTBI
The Patient...

_____is a current high risk contact of a person known or suspected to have TB disease: Name of Source case: _____

_____has been in another country for - 3 or more months - where TB is common, and has been in the US for ≤ 5 years

_____is a resident or an employee of a high TB risk congregate setting

_____is a healthcare worker who serves high-risk clients

_____is medically underserved

_____has been homeless within the past two years

_____is an infant, a child or an adolescent exposed to an adult(s) in high-risk categories

_____injects illicit drugs or uses crack cocaine

_____is a member of a group identified by the health department to be at an increased risk for TB infection

_____needs baseline/annual screening approved by the health department

B. Assess Risk for Developing TB Disease if Infected
The Patient...

_____is HIV positive

_____has risk for HIV infection, but HIV status is unknown

_____was recently infected with *Mycobacterium tuberculosis*

_____has certain clinical conditions, placing them at higher risk for TB disease: _____

_____injects illicit drugs (determine HIV status): _____

_____has a history of inadequately treated TB

_____is >10% below ideal body weight

_____is on immunosuppressive therapy (this includes treatment for rheumatoid arthritis with drugs such as Humira, Remicaid, etc.)

History of BCG / TB Skin Test / TB Treatment:

History of prior BCG: ___NO ___YES➔Year: _____

History of prior (+) TST: ___NO ___YES

Date of (+) TST _____ Reading: _____mm

CXR Date: _____ CXR result: ___ABN ___WNL

Dx: ___LTBI ___Disease

Tx Start: _____ Tx End: _____

Rx: _____

Completed: ___NO ___YES

Location of Tx: _____

III. Finding(s) *(Check all that apply)*

_____Previous Treatment for LTBI and/or TB disease

_____No risk factors for TB infection

_____Risk(s) for infection and/or progression to disease

_____Possible TB suspect

_____previous positive TST, no prior treatment

IV. Action(s) *(Check all that apply)*

_____Issued screening letter   _____Issued sputum containers

_____Referred for CXR   _____Referred for medical Evaluation

_____Administered the Mantoux TB Skin Test

_____Draw interferon-gamma release assay

_____Other: _____

___#1 TST Lot#_____ or ___ IGRA (Check One)

Date Given or Drawn _____ Time _____ Site_____

Signature _____ POS#_____

TST READING/ IGRA Results Date Read_____

Time _____ Signature _____POS#_____

Induration _____mm ___Pos ___Neg (TST or IGRA)

_____Borderline/Indeterminate – IGRA ONLY

___#2 TST Lot#_____ or ___ IGRA (Check One)

Date Given or Drawn _____ Time _____ Site_____

Signature _____ POS#_____

TST READING/ IGRA Results Date Read_____

Time _____ Signature _____POS#_____

Induration _____mm ___Pos ___Neg (TST or IGRA)

_____Borderline/Indeterminate – IGRA ONLY

Screener's signature:_____

Screener's name(print):_____

Date: _____ Phone #:_____

- I hereby authorize the doctors, nurses, or nurse practitioners of the Virginia Department of Health to administer the Tuberculin Skin Test (PPD) or draw blood for an IGRA test from me or my child named above.
- I agree that the results of this test may be shared with other health care providers.
- The Deemed Consent for blood borne diseases has been explained to me and I understand it.
- I acknowledge that I have received the Notice of Privacy Practices from the Virginia Department of Health.
- I understand that: • this information will be used by health care providers for care and for statistical purposes only.
    - this information will be kept confidential.
    - medical records must be kept at a minimum for 10 years after my last visit, 5 years after death; for minor children, 5 years after the age of 18, or 10 years after the last visit, whichever is greater.

X _____ Date: _____