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: ________ Interpreter needed: ___No __Yes Last Live Vaccine:__________

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: __________
___lived in or visited another country where TB is common for 3 months or more, regardless of length of time in the U.S.
___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 testing 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 – includes treatment with TNF-α antagonists (Remicaid, Humira, etc.), other biologic response modifiers or prednisone ≥ 1 mo. ≥15 mg/day

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 SkinTest (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: __________

Client or Parent/Guardian Signature

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