SENTARA®

OCCUPATIONAL HEALTH SERVICES

TUBERCULOSIS (TB) RISK ASSESSMENT

Adapted from: Virginia Department of Health
Division of TB Control TB Risk Assessment Form (TB 512)

Screen for TB Infection Risk

Individuals with an increased risk for acquiring latent TB infection (LTBI) or for progression to active disease once infected should have a Tuberculin Skin Test (TST)/Interferon-Gamma Release Assay (IGRA). Screening for persons with a history of LTBI should be individualized.

To be completed by individual being screened for TB:

Today's Date	Name		Soc Sec #
Date of Birth	Job Title: Student	Work Location: Sentara Williamsburg Regional Medical Center	Parent Work Phone #

I hereby authorize the doctors, nurses, or nurse practitioners of Sentara Healthcare to administer the Tuberculin Skin Test (TST) or draw blood for an IGRA test from me. I agree that the results of this test may be shared with other health care providers or regulatory agencies as required by law. I understand that this information will be kept confidential and will be used by health care providers for care and for statistical purposes only.

Signature: **X** _____ Date: _____

I. Please answer all questions below:	N/A	NO	YES
Since your last TB review, have you had any of the following symptoms for **more than 3 weeks** at a time? **(If you have no symptoms, check NONE; otherwise, check all symptoms that apply).** ☐ Persistent coughing ☐ Productive ☐ Yes ☐ No ☐ Excessive unexplained weight loss ☐ Excessive sweating at night ☐ Persistent unexplained fever ☐ Hoarseness ☐ Poor appetite ☐ Excessive fatigue ☐ Coughing up blood ☐ **NONE**			
Since your last TB review have you:			
Worked with, or have had close personal contact with someone with active TB disease?	○	○	○
Had an abnormal chest x-ray or abnormal CT scan of the chest?	○	○	○
Had healthcare practitioner told you that your immune system isn't working or can't fight infection?	○	○	○
Traveled outside the United States? If yes, where?	○	○	○
Previously had a positive TB skin test? If so, when and where?	○	○	○
Were you evaluated by a physician for the positive TB test?	○	○	○
Were you prescribed any medication? If yes, what medication and length of time taken?	○	○	○

OCCUPATIONAL HEALTH NURSE (OHN): Document assessment of individual's information using current guideline found @ CDC. MMWR. Guidelines for preventing the transmission of mycobacterium tuberculosis in health-care settings. 2005; 54: 1-141. http://www.cdc.gov/mmwr/PDF/rr/rr5417.pdf ***Refer to Sections A and B on page 2 of form for related criteria; document in medical record.**

Reason for Screen (check one or more if applicable): ☐ **Pre placement** ☐ **Annual** ☐ **Post Exposure Follow-up**

__#1 TST Lot#_____ or __ IGRA **(Check One)**

Date Given or Drawn _____ Time _____ Site_____

Nurse's Signature _____

TST READING/ IGRA Results

Date Read_____ Time _____

Signature _____

Induration ____mm ___Positive ___Negative **(TST or IGRA)**

__**Borderline/Indeterminate – IGRA ONLY**

__#2 TST Lot#_____ or __ IGRA **(Check One)**

Date Given or Drawn _____ Time _____ Site_____

Nurse's Signature _____

TST READING/ IGRA Results

Date Read_____ Time _____

Signature _____

Induration ____mm ___Positive ___Negative **(TST or IGRA)**

__**Borderline/Indeterminate – IGRA ONLY**

III. SCREENING DISPOSITION – OHN to complete based on Risk Assessment Criteria (Indicate findings based on assessment in all previous sections).

Check all that apply:

___No risk factors for TB infection documented
___ Previous Treatment for LTBI and/or TB disease
___Risk(s) for infection and/or progression to disease
___Possible TB suspect
___ Previous positive TST, no prior treatment

IV. ACTIONS TAKEN - OHN to indicate the action(s) to take as a result of the findings in Section III.

Check all actions that apply:

___ Issued Report of Tuberculosis Screening Letter
___ Administered Mantoux TB Skin Test (TST)
___ Collected specimen for Interferon Gamma Release Assay (IGRA)
___ Referred for CXR
___ Referred for Medical Evaluation

OH Nurse Signature **Date**