Adult Tuberculosis (TB) Risk Assessment Questionnaire*

(To satisfy California Education Code Section 49404 and Health and Safety Code Section 121525-121555)
To be administered by a licensed health care provider (physician, physician assistant, nurse practitioner)

Please complete this Questionnaire. Our District Nurse will review this Questionnaire and will contact you if any questions should arise.

Name: _____

Date of Birth: _____ **Date of Risk Assessment:** _____

Do you have a History of positive TB test or TB Disease? (Y/N) _____
If yes, a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire.

If there is a "Yes" response to any of the questions below, a Tuberculosis Skin Test (TST) or interferon Gamma Release Assay (IGRA) should be performed. A positive test should be followed by a chest x-ray, and if normal, treatment for TB infection considered.

Risk Factors:

1. Have you experienced one or more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue)? (Y/N) _____
   Note: A chest x-ray and/or sputum examination may be necessary to rule out infectious TB**
2. Have you been in close contact with someone with infections TB disease? (Y/N) _____
3. Are you a Foreign-born person? (Y/N) _____
   (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)
4. Are you a traveler to high TB-prevalence country for more than one month? (Y/N) _____
   (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)
5. Are you a current or former resident or employee of correctional facility, long-term care facility, hospital, or homeless shelter? (Y/N) _____

Once a person has a documented positive test for TB infection that has been followed by an x-ray deemed free of infectious TB, the TB risk assessment is no longer required.
The above named patient has submitted to a tuberculosis risk assessment, and if tuberculosis risk factors were identified, has been examined and determined to be free of infectious tuberculosis.

_____
Health Care Provider Signature **Date**

_____
Health Care Provider Name **Title**

_____
Office Address

_____
Telephone

*Adapted from a form developed by Minnesota Department of Health TB Prevention and Control Program and Centers for Disease Control and Prevention.
**Centers for Disease Control and Prevention (CDC). Latent Tuberculosis infection: A Guide for Primary Health Care Providers. 2013 (http://cdc.gov/tb/publications/LTBI/default.htm
California Tuberculosis Controllers Association