



## Adult Tuberculosis (TB) Risk Assessment Questionnaire<sup>1</sup>

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)

To be administered by a licensed health care provider (physician, physician assistant, nurse practitioner, registered nurse)

Name: \_\_\_\_\_ Date of Risk Assessment: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

History of positive TB test or TB disease Yes  No

If yes, a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire.\*  
If no, continue with questions below.

If there is a “Yes” response to any of the questions 1-5 below, then a tuberculin 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		Yes <input type="checkbox"/>	No <input type="checkbox"/>
1.	One or more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue) Note: A chest x-ray and/or sputum examination may be necessary to rule out infectious TB. <sup>2</sup>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.	Close contact with someone with infectious TB disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.	Birth in high TB-prevalence country** (*Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.	Travel to high TB-prevalence country** for more than 1 month (*Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5.	Current or former residence or work in a correctional facility, long-term care facility, hospital, or homeless shelter	Yes <input type="checkbox"/>	No <input type="checkbox"/>

*\*Once a person has a documented positive test for TB infection that has been followed by an x-ray that was deemed free of infectious TB, the TB risk assessment is no longer required.*

<sup>1</sup> Adapted from a form developed by Minnesota Department of Health TB Prevention and Control Program and Centers for Disease Control and Prevention.

<sup>2</sup> Centers for Disease Control and Prevention (CDC). *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers*. 2013.

(<http://www.cdc.gov/tb/publications/LTB/default.htm>)



**ADULT TUBERCULOSIS (TB) RISK ASSESSMENT QUESTIONNAIRE**

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)

**CERTIFICATE OF COMPLETION**

*To be signed by the licensed health care provider completing the risk assessment and/or examination*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

*The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.*

Health Care Provider Signature \_\_\_\_\_

Please Print Health Care Provider Name \_\_\_\_\_ Title \_\_\_\_\_

Office Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_