TB Risk Assessment Form

Employee Name: ____

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Risk for Acquiring TB (*To be completed by employee)*

(check all that apply)

- ❏ Person is currently in close contact of a person known or suspected to have TB.
- ❏ Person has lived in a country where TB is common, for 3 or more months, and has been in the US for less than 5 years.
- ❏ Person is a resident or employee of a high risk group setting, such as a nursing home, shelter, prison or jail.
- ❏ Person works in a healthcare setting with high-risk clients.
- ❏ Person is medically underserved. (no personal doctor or doctor visit within the last 2 years).
- ❏ Person has been homeless within the last two years.
- ❏ Person has previously tested positive for TB.

To the best of my knowledge, the information I have provided above is accurate.

____

Employee Signature *Date*

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TB Symptoms Screening *(To be evaluated by RN)*

(check all that apply)

- ❏ Cough for > 3 weeks
- ❏ Unexplained fever
- ❏ Coughing blood
- ❏ Unexplained weight loss
- ❏ Poor appetite
- ❏ Night Sweats
- ❏ Fatigue

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Results of TB Screening *(To be completed by RN)*

Based on the available information:

- ❏ *The individual is free of communicable TB.*
- ❏ *Tuberculosis cannot be ruled out in the individual listed above. The individual has been referred to their physician or local health department for further evaluation.*

Name: ____ RN

Signature: ____ RN

Date: ______________________________