**Adult Tuberculosis (TB) Risk Assessment and Screening Form**

This form is to be completed annually for all employees having contact with service recipients and filed in his/her employee file.

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| Employee Name: |  | Date Completed: |  |

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| **EMPLOYEE TO ANSWER QUESTIONS BELOW:** | |
| Have you ever had a positive TB test or had tuberculosis?  If yes, you will need to present a report to your supervisor from your health care provider about your status, including results of a chest x-ray, which has been performed in the past 6 months in the U.S.A. | □ Yes □ No |
| **TB Risk Factors** | |
| 1. Have you had contact or lived with someone who has been sick with TB in the last 2 years? | □ Yes □ No |
| 1. Were you born in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean, or the Middle East? If yes, what country?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Yes □ No |
| 1. Have you spent more than 30 days in a one of the foreign countries above in the last five years? If yes, what county/countries?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Yes □ No |
| 1. Have you ever worked or lived in a correctional facility, long-term care facility, hospital, homeless shelter, or an alcohol and drug treatment center? | □ Yes □ No |
| 1. Have you ever been an intravenous drug user? | □ Yes □ No |
| **TB Symptom Screening – At this time, do you have any of the following symptoms?** | |
| 1. Coughing for more than 2-3 weeks? | □ Yes □ No |
| 2. Coughing up blood? | □ Yes □ No |
| 3. Weight loss of more than 10 pounds without trying to lose weight? | □ Yes □ No |
| 4. Fever of 100⁰ F (or 38⁰ C) for over 2 weeks? | □ Yes □ No |
| 5. Unusual or heavy sweating at night? | □ Yes □ No |
| 6. Unusual weakness or extreme fatigue? | □ Yes □ No |
| 7. Loss of appetite | □ Yes □ No |
| **FOR REVIEWER USE ONLY:** | |
| **Review of Information and Required Follow-up** | |
| Are there “yes” marks in 1 or more boxes under “TB Risk Factors”? | □ Yes □ No |
| Are there “yes” marks in 2 or more boxes under “TB Symptom Screening”? | □ Yes □ No |
| If one or none of the “yes” boxes in this section are checked, no follow-up is needed by the employee. | |
| If both of the “yes” boxes in this section are checked, the employee is to be referred to their personal physician or the local Health Department for an evaluation. A report is to be provided to the supervisor.  Was employee referred to private physician/local Health Department for follow-up?  If yes, date referred:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reviewer Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Reviewed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Yes □ No |