

**A. SELF-ASSESSMENT (TO BE COMPLETED BY PATIENT OR PARENT / GUARDIAN)**

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
Street Apt. # City State Zip Code

Phone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Home Cellular Emergency Number

1. Have you ever had a TB skin test? Yes No Don't know
  - If yes, when was it? \_\_\_\_/\_\_\_\_/\_\_\_\_ • What was the result? Positive Negative Don't know
  - If positive, do you have the documentation? Yes No
2. Did you have a chest x-ray after your skin test? Yes No
  - If yes, when? \_\_\_\_/\_\_\_\_/\_\_\_\_
  - Where was it? (e.g., name of hospital, doctor, clinic) \_\_\_\_\_
3. Have you ever been told that you have TB? If so, when: \_\_\_\_/\_\_\_\_/\_\_\_\_
4. Have you ever been treated for TB infection or TB disease? Yes No
  - Which medicines did you take? \_\_\_\_\_
  - How long were you on the treatment? \_\_\_\_\_

Please place a <input checked="" type="checkbox"/> mark in one of the columns to the right	Yes	No	Don't Know
5. Have you ever been told, or suspected, that you were exposed to someone with TB? • If yes, when: ____/____/____ Name /Relationship: _____			
6. Have you ever had cancer of the head, neck or lung; leukemia; or lymphoma?			
7. Have you ever had an organ or tissue transplant?			
8. Are you taking steroids (like prednisone), chemotherapy or drugs that affect your immune system?			
9. Do you have diabetes or high blood sugar?			
10. Do you have any of the following symptoms:			
• Cough longer than 2 weeks? If yes, date you first noticed ____/____/____			
• Fever, chills, night sweats longer than 2 weeks? If yes, date you first noticed ____/____/____			
• Weight loss that was not planned? If yes, date you first noticed ____/____/____			
11. Do you have renal failure, or are you on kidney dialysis?			
12. Do you think you are at risk of having HIV infection?			
13. Have you ever injected street drugs?			
14. Were you born outside of the United States? If yes, what country? _____			
15. (If patient under 18) Has anyone who lives with you moved to the U.S. within the last 5 years? If so, from which country? _____			
16. Have you had any visitors from outside the U.S.? When? _____ Where were they from? _____			
17. Have you traveled to any other countries recently? Where? _____ How long did you stay? _____			
18. Have you ever lived or worked in a group setting such as a hospital, nursing home, drug treatment center, homeless shelter, jail, or prison?			

*If you answered "Yes" to any of the questions from 5 to 18, you may be at increased risk of having TB infection or developing active TB. If you answered "No" to all, you are not considered at higher risk for TB.*

\_\_\_\_\_  
 Patient or Parent/Guardian Signature

FACILITY STAMP

PATIENT'S NAME: \_\_\_\_\_  
Last First Middle

D.O.B.: \_\_\_/\_\_\_/\_\_\_

**B. ASSESSMENT OUTCOME AND TB TEST ADMINISTRATION (TO BE COMPLETED BY CLINICIAN)**

**Prior Documentation (or convincing history) of TB or LTBI:**

No TB test needed. *Patient may still need evaluation for treatment for LTBI or active TB.*

**TB Risk Category (check one box only):**

- Medical risk factor (includes contacts to active TB cases)** (questions 5-12)
- Population risk factor** (questions 13-18)
- Administrative** (TB test required only for work, school, etc.)

**Screening Test:**  **TST (PPD) Mantoux** (0.1ml of tuberculin)  **Blood Test** (QuantiFERON TB Gold)

Test Date: \_\_\_/\_\_\_/\_\_\_

**Tuberculin lot number:** \_\_\_\_\_ **Expiration date:** \_\_\_/\_\_\_/\_\_\_

Date interpreted \_\_\_/\_\_\_/\_\_\_ Result: \_\_\_\_\_mm  Positive  Negative

**Blood test IFN- $\gamma$  concentration:** \_\_\_\_\_ IU/mL

Result:  Positive  Negative  Indeterminate

**Two Step Testing for Health Care Workers** (applicable only if initial TST was negative):

2<sup>nd</sup> TST Mantoux date: \_\_\_/\_\_\_/\_\_\_

**Tuberculin lot number:** \_\_\_\_\_ **Expiration date:** \_\_\_/\_\_\_/\_\_\_

Date interpreted \_\_\_/\_\_\_/\_\_\_ 2<sup>nd</sup> result: \_\_\_\_\_mm  Positive  Negative

**PHYSICAL EXAM:** Date: \_\_\_/\_\_\_/\_\_\_  *No signs of TB*  *Abnormal, Suggesting TB*

**CHEST X-RAY:** Date: \_\_\_/\_\_\_/\_\_\_ Reading: \_\_\_\_\_

**OUTCOME (check one box only):**

- |   |  |
|---|--|
| <input type="checkbox"/> LTBI treatment prescribed            | <input type="checkbox"/> Patient being evaluated as a TB suspect             |
| <input type="checkbox"/> No treatment needed (Not infected)   | <input type="checkbox"/> Patient refused treatment                           |
| <input type="checkbox"/> No treatment indicated (Low TB risk) | <input type="checkbox"/> Treatment not advised due to high risk of hepatitis |
| <input type="checkbox"/> Treatment deferred due to _____      | <input type="checkbox"/> Previously treated for TB or LTBI                   |
|   | <input type="checkbox"/> Other _____   |

**Follow-up/Comments (include treatment regimen):**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
Name (Please Print) Signature Date

