Tennessee Department of Health
TB Elimination Program

TB RISK ASSESSMENT TOOL

A. DEMOGRAPHICS *(place PTBMIS label here):*

Name (Last, First, MI): _____
Date of birth (mm/dd/yyyy): _____/_____/_____
Race: W B A P N O *(specify):*_____
Gender: M F
Home address: _____
SS#: _____-_____-_____

Hispanic: Y N
Home/cell phone: (_____)_____-_____
Work phone: (_____)_____-_____
Insurance/Medicaid: _____
Occupation/Employer: _____
County of residence: _____
Country of origin: _____
Primary language: _____
Month/year of US entry *(mm/yyyy):* ____/_____

<For targeted testing use only>

Site name: _____
Site address: _____
Site county: _____

Site type: _____
Site #: _____
Site contact person: _____
Site contact phone: (_____)_____-_____

B. RISK FACTORS FOR TB EXPOSURE

Y N Foreign-born, high risk areas *(see list in PHN protocol)*
Y N Congregate setting ever *(circle):*
Correctional (yr) _____ Homeless shelter (yr) _____
Long-term care (yr) _____
Y N Close TB contact (yr)*:* _____
Y N Child around adult with TB risk factor

Has the patient ever:
Y N Been homeless
Y N Been a high-risk health care worker
Y N Injected drugs
Y N Used non-injecting drugs
Y N Had excessive alcohol use/abuse
Y N Traveled/resided in high-risk area (yr)_____

C. RISK FOR PROGRESSION TO TB DISEASE

Y N Diabetes
Y N Silicosis
Y N Leukemia or lymphoma
Y N Cancer of the head and neck or lung
Y N Immunosuppressive condition or therapy
Y N Known HIV
Y N Infant/child <5 years
Y N Endstage kidney disease
Y N Gastrectomy or jejunoileal bypass
Y N Weigh <90% of ideal body weight
Y N Pre/post transplant
Y N Untreated/inadequate TB treatment
Y N Diagnosed with TB infection (w/in past 2 yrs)
Y N Smoking

D. HISTORY FOR PREVIOUS DIAGNOSIS OF TB DISEASE / TB INFECTION

Y N Previous positive TST
Y N Previous positive IGRA
Y N Previous diagnosis of TB disease/TB infection *(circle one)*
Y N Previous completion of therapy for TB disease/TB infection *(circle one)* Year completed*:* _____

Y N HIV risk factors Previous HIV test (yr) _____ Previous HIV result: _____

E. TB SYMPTOMS: *(if present,notify nurse or doctor immediately)*

Y N Cough ≥ 2-3 wks
Y N Hemoptysis
Y N Weight loss
Y N Night sweats
Y N Fever

F. RISK OF TB INFECTION *(circle):* **HIGH** *(apply TST or draw IGRA)* **LOW** *(TB education only)*

Y N Counseled on risk of TB disease/infection
Y N TST placed ____/____/____ Read: ____/____/____ Result (mm) _____
Y N 2nd TST placed ____/____/____ Read: ____/____/____ Result (mm) _____
Y N IGRA drawn ____/____/____ Result *(circle one):* **P** - Positive **N** - Negative **I** - Indeterminate
Y N 2nd IGRA drawn ____/____/____ Result *(circle one):* **P** - Positive **N** - Negative **I** - Indeterminate

COMPLETED BY: _____ _____ _____/_____/_____
Print name Signature Date