

Symptom/TB Questionnaire:

All Positive Skin test reactors and all non-patient care staff must complete this form ANNUALLY.

Please Print:			
Name: _____	Department: _____		
Employee ID #: _____	Date: _____	Worksite: _____	

In order to comply with OSHA standards, all healthcare personnel, and volunteers must periodically be assessed for M. tuberculosis. Please read the following information, answer the questions, sign and date the questionnaire.

I am an Associate/Volunteer who is **not** in the following high risk TB areas: Yes No
Emergency Room, Work and Wellness, Pulmonary Medicine, Respiratory Therapy, All Float Nurses, Convenient Care, Security and Interpreter Services.

Do you have a history of positive TB Test (TST or IGRA) or TB disease? Yes No

Have you been treated for TB disease or infection Yes No

Follow-up for positive TB Test(s)

- An initial positive tuberculin skin test (TST) or interferon Gamma Release Assay (IGRA; blood test) should be followed by a thorough medical exam and chest x-ray (CXR), to assure that the patient does not have TB disease. If no disease is found, the person should be offered treatment for LTBI
- Once a person has a documented positive TST or IGRA followed by a CXR deemed to be free of infectious TB, further CXR are **not** needed unless the patient has signs or symptoms of TB disease, or unless ordered by a physician for specific diagnostic examination.
- A screening risk assessment for exposure to TB disease should be **repeated** even if a person has been treated for previous TB disease or infection, as TB infection can occur more than once. A new risk factor for TB disease exposure should be followed by symptom review, medical exam, and CXR. Retesting (TST or IGRA) would not be helpful, as the patient already has a positive test.

Follow up for TB Screening Risk Assessment:

- If there is a "Yes" response to any of the five questions below since last assessment, then a TST or IGRA should be performed. A positive test should be followed by a medical exam and chest x-ray (CXR), and, if normal, treatment for LTBI is advised.
- Re-TESTING by TST or IGRA should only be done in persons who previously tested negative, and who have risk factors since the last assessment.

Risk Assessment Questionnaire Screen to Exposure of TB Disease:

1. I have a persistent cough lasting 3 or more weeks AND one or more of the following symptoms: coughing up blood, fever, night sweats, unexplained weight loss, excessive fatigue. <i>Note: A chest X-ray and/or sputum examination may be necessary to rule out infectious TB.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I have been exposed to someone with a known infectious TB disease or lived with or had close contact with someone who has TB disease.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I was born in a high TB-prevalence country (any country other than the US, Canada, Australia, New Zealand, or a country in Western or Northern Europe).	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I have traveled to a high TB-prevalence country for more than one month . <i>Note: High TB-prevalence countries include any country other than the US or Canada, Australia, New Zealand, or a country in Western or Northern Europe</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. I am a current or former resident or worked in a high-risk setting in a state/district with higher TB prevalence (Alaska, California, Florida, Hawaii, New Jersey, New York, Texas, or Washington DC).	<input type="checkbox"/> Yes <input type="checkbox"/> No

I have read and understand the information provided.

Signature _____

Date _____

Certification of Completion

To be completed by the Nurse reviewing the TB risk assessment Questionnaire.

- A Tuberculosis risk assessment has been completed for the individual. The associate/volunteer does not have risk factors, or if TB risk factors were identified, he/she has been examined and determined to be free of infectious tuberculosis.

- The individual has a history of a previous positive TB test. A TB symptoms review and /or chest X-ray was completed, and the person is determined to be free of infectious tuberculosis.

Nurse Signature _____

Date _____