Sent for review _____

# Adult Tuberculosis (TB) Risk Assessment Questionnaire

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)
This risk assessment will be reviewed by a licensed health care provider (physician, physician assistant, registered nurse, nurse practitioner)

**Employee** ☐ **Non-Employee** ☐

Name: _____ Date: _____

Site/Title: _____ Home/Cell Phone Number: _____

*History of positive TB test or TB disease?* **Yes** ☐ **No** ☐

*If yes, a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire.*

If there is a "Yes" response to any of the questions #1-5 below, then an appointment with a CUSD Registered Nurse must be completed to determine whether a tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) should be performed. A positive test should be followed by a chest x-ray, and if normal, treatment for TB infection considered.

| **Risk Factors** | | | |
|---|---|---|---|
| 1. | Do you have one or more signs and symptoms of TB (***prolonged*** cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue.) | Yes ☐ | No ☐ |
| 2. | Since your last TB test have you had close contact with someone with infectious TB disease? | Yes ☐ | No ☐ |
| 3. | Are you a foreign-born person? (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.) | Yes ☐ | No ☐ |
| 4. | Have you stayed in a high TB-prevalence country for more than 1 month since your last TB test? (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.) | Yes ☐ | No ☐ |
| 5. | Are you a current or former resident or employee of a correctional facility, long-term care facility, hospital, or homeless shelter? | Yes ☐ | No ☐ |

**By signing below, I certify all information is true and correct to the best of my knowledge.**

_____ _____
Signature of Applicant Date Signed

Referral for Testing: **YES** ☐ **NO** ☐

Tuberculin skin test or Interferon Gamma Release Test Completed: Date: _____ Chest X-Ray Completed: Date: _____

***The above named patient has submitted to a tuberculosis risk assessment, and if tuberculosis risk factors were identified has been examined and determined to be free of infectious tuberculosis.***

_____ _____
Health Care Provider Signature Date

Health Care Provider: **Deborah Taylor** Title: **RN**

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Fg 8/28/18