



Kentucky Department For Public Health Tuberculosis (TB) Risk Assessment

Patient name (L,F,M): _____ DOB: _____ Race: _____ Sex: _____ SSN: _____
 Address: _____ City, State, Zip: _____
 Home/Work #: _____ Cell# _____ Patient Pregnant: _____ No _____ Yes; If Yes, LMP _____
 Language: _____ Country of Origin: _____ Year arrived in US: _____ Interpreter needed: _____ No _____ Yes
 Allergies: _____ Current Medications: _____

I. Screen for Active TB Symptoms (Check all that apply)

- None (Skip to Section II, "Screen for TB Infection Risk")
- Cough for ≥ 3 weeks \rightarrow Productive: YES NO
- Hemoptysis
- Fever, unexplained
- Unexplained weight loss
- Poor appetite
- Night sweats
- Fatigue

Evaluate these symptoms
in context

**Pediatric Patients
(≤ 5 years of age):**

- Wheezing
- Failure to thrive
- Decreased activity,
playfulness and/or energy
- Lymph node swelling
- Personality changes

II. Screen for TB Infection Risk (Check all that apply)

Individuals with an increased risk for acquiring latent TB infection (LTBI) or for progression to active disease once infected should have a TST. Screening for persons with a history of LTBI should be individualized.

A. Assess Risk for Acquiring LTBI. The Patient:

- is a current high risk contact of a person known or suspected to have TB disease.
- has been in another country for - 3 or more months where TB is common, and has been in the US for ≤ 5 years
- is a resident or an employee of a high TB risk congregate setting
- is a healthcare worker who serves high-risk patients
- is medically underserved
- has been homeless within the past two years
- is an infant, a child or an adolescent exposed to an adult(s) in high-risk categories
- injects illicit drugs or uses crack cocaine
- is a member of a group identified by the health department to be at an increased risk for TB infection
- needs baseline/annual screening approved by the health department

B. Assess Risk for Developing TB Disease if Infected The Patient...

- is HIV positive
- has risk for HIV infection, but HIV status is unknown
- was recently infected with *Mycobacterium tuberculosis*
- has certain clinical conditions, placing them at higher risk for TB disease: _____
- injects illicit drugs (determine HIV status): _____
- has a history of inadequately treated TB
- is $>10\%$ below ideal body weight
- is on immunosuppressive therapy (this includes treatment for rheumatoid arthritis with drugs such as REMICADE, HUMIRA, etc.)

History of BCG / TB Skin Test / BAMT / TB Treatment:

History of prior BCG: NO YES \rightarrow Year: _____
 History of prior (+) TST or (+) BAMT: NO YES
 Date (+) TST / (+) BAMT _____ TST: _____mm
 CXR Date: _____ CXR result: ABN WNL
 Dx: LTBI Disease
 Tx Start: _____ Tx End: _____
 Rx: _____
 Completed: NO YES
 Location of Tx: _____

III. Finding(s) (Check all that apply)

- Previous Treatment for LTBI and/or TB disease
- No risk factors for TB infection
- Risk(s) for infection and/or progression to disease
- Possible TB suspect
- Previous (+) TST or (+) BAMT, no prior treatment

IV. Action(s) (Check all that apply)

- Issued screening letter Issued sputum containers
- Referred for CXR Referred for medical evaluation
- Administered the Mantoux TB Skin Test
- Draw BAMT / Interferon-gamma Release Assay ((IGRA)
- Other: _____

TST Brand/Lot # _____ TST Brand/Lot# _____

Arm: <input type="checkbox"/> Left <input type="checkbox"/> Right	Arm: <input type="checkbox"/> Left <input type="checkbox"/> Right
Date/Time _____	Date/Time _____
Induration _____mm	Induration _____mm

BAMT T-SPOT.TB QFT-TB-G-IT

Date/Time drawn: _____
 Result: Pos Neg Borderline/Indeterminate

Screener's signature: _____
 Screener's name (print): _____
 Screener's title: _____
 Date: _____ Phone #: _____
 Comments: _____

- I hereby authorize the doctors, nurses, or nurse practitioners of the _____ Department for Public Health to administer a Tuberculin Skin Test (TST) or draw blood from me or my child named above for a Blood Assay for *Mycobacterium tuberculosis* (BAMT) test.
- I agree that the results of this test may be shared with other health care providers.
- I understand that:
 - this information will be used by health care providers for care and for surveillance /statistical purposes only.
 - this information will be kept confidential

X _____ Date: _____

IMPORTANT: A decision to test is a decision to treat. Given the high rates of false positive TB skin test results, the Kentucky TB Prevention and Control Program discourages administration of the Mantoux TST to persons who are at a low risk for TB infection.

CDC LTBI: A Guide for Primary Health Care Providers

Sample Risk Assessment

<http://www.cdc.gov/tb/publications/ltbi/appendixa.htm>