TUBERCULOSIS RISK ASSESSMENT

Tool for use by a licensed healthcare provider (M.D., D.O., N.D., P.A., ARNP) only.

Have this form completed by a healthcare provider ONLY if you are a person at high risk for TB exposure or infection.

TUBERCULOSIS RISK ASSESSMENT

Persons with any of the following are candidates for either the Mantoux tuberculin skin test (TST) or the Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

*Risk Factors:

- Recent close contact with someone with infectious TB disease? □No □Yes
- Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America)? □No □Yes
- Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease? □No □Yes
- HIV/AIDS diagnosis? □No □Yes
- Organ-transplant recipient? □No □Yes
- Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF-α antagonist)? □No □Yes
- History of illicit drug use? □No □Yes
- Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facility, nursing home, homeless shelter, hospital, other healthcare facility)? □No □Yes
- Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin’s disease or leukemia, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)]]? □No □Yes

* The significance of the exposure should be discussed and evaluated with a healthcare provider.

1. Does the student have signs or symptoms of active tuberculosis disease? □No □Yes
   If no, proceed to number 2 or 3. If yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)
   TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write “O.” The TST interpretation should be based on mm of induration as well as risk factors.**

   Date given: ____/____/____    Date read: ____/____/____
   M      D        Y            M      D        Y
   Result: _______ mm of induration    Interpretation: Positive____ Negative____

   Date given: ____/____/____    Date read: ____/____/____
   M      D        Y            M      D        Y
   Result: _______ mm of induration    Interpretation: Positive____ Negative____

   Date obtained: ___/___/___
   M      D        Y
   ☐ QFT-G
   ☐ QFT-GIT
   ☐ T-Spot
   ☐ Other _____

   Result: ☐ Negative    ☐ Positive    ☐ Indeterminate    ☐ Borderline: T-spot only

   Date Obtained: ___/___/___
   M      D        Y
   ☐ QFT-G
   ☐ QFT-GIT
   ☐ T-Spot
   ☐ Other _____

   Result: ☐ Negative    ☐ Positive    ☐ Indeterminate    ☐ Borderline: T-spot only

4. **Chest X-ray: required if TST or IGRA is positive**

   Date of chest X-ray: ___/___/___
   M      D        Y

   Result: Normal___ Abnormal_____

**Provider Statement:**

I am a qualified and licensed healthcare provider (M.D., D.O., N.D., P.A., ARNP). I confirm that I have completed the TUBERCULOSIS (TB) RISK ASSESSMENT form for the student named above. I also confirm that I have discussed with the student (or parent or guardian if student is under 18 years of age) information regarding results of any TB testing and further follow-up or treatments that may be necessary.

X

SIGNATURE of licensed healthcare provider (M.D., D.O., N.D., P.A., ARNP) DATE

Please submit this Tuberculosis Risk Assessment form AFTER you have submitted the Tuberculosis Questionnaire form via the Student Health Portal. You can upload this Risk Assessment form through the Student Health Portal, by mail, or fax.

**Student Health Portal:** https://pyramed.whitworth.edu/my.policy

**Mail:**

Whitworth University Health Center
300 West Hawthorne Road
Spokane, WA  99251

**Fax:** 509-777-4333