CABELL-HUNTINGTON HEALTH DEPARTMENT

West Virginia Department of Health and Human Resources
Division of Tuberculosis Elimination
School TB Risk Assessment Form

Please PRINT Neatly

Patient Name: _____ Phone: (_____)_____
Address: _____ City: _____
State: _____ Zip Code: _____ S.S.N.: _____
Birth Date: _____ Age: _____ Race: _____ Circle One: Male / Female

Do you have any of the following symptoms or conditions?

Yes No Cough (un-explained and lasting **longer than** 3 weeks)
Yes No Fever (for un-known reason)
Yes No Coughing up blood
Yes No Loss of weight (un-explained / not planned)
Yes No Loss of appetite
Yes No Night Sweats
Yes No Fatigue
Yes No Diabetes
Yes No COPD, Silicosis, or Black Lung
Yes No A diagnosis of HIV?
Yes No An impaired immune system?
What is the cause? _____

Have you …

Yes No Had recent contact with someone that has ACTIVE TB? (needs state approval)
Yes No Recently (within the past 2 years) **been or currently are homeless?**
Yes No Were you born in a country outside of the United States of America?
If YES then please list the country: _____

Do the following apply to you?

Yes No A positive TB Skin Test? (PPD)
Yes No Have you ever had a T-Spot (blood test for TB) **before?**
****Was it positive? Yes No**
Yes No Have you ever taken the BCG vaccine?
****Was it for cancer treatment? Yes No**
Yes No Do you need a TB test or T Spot for immigration purposes?

Have you recently had or have a history of …

Yes No Cancer of the head and/or neck? When: _____
Yes No Leukemia? When: _____
Yes No Any other form of cancer?
Please list what kind / where and when: _____
Yes No Kidney Disease?
Yes No Intestinal Bypass Surgery?
Yes No Gastrectomy Surgery?
Yes No A disease that requires medications that decrease your immune system?
What medication(s)? _____

Are you requesting a TB Test because …

Yes No You visited another country for 2 months or longer?
Please list the country, when, and the amount of time:_____

Yes No You lived in another country for any length of time?
Please list the country, when, and the amount of time:_____

Yes No My employer is requiring me to have this test.
**** Name of Employer _____**

Yes No My higher education institution (college/ vocational school is requiring me to have this test.

Yes No You are a <u>COLLEGE STUDENT</u> who is entering into a classroom, daycare, or hospital to do observation or an internship/ externship?

Yes No You are a <u>HIGH SCHOOL STUDENT</u> who is entering into a classroom, daycare, or hospital to do observation or an internship/ externship?

Yes No You currently are or are applying to be a foster parent or for adoption purposes?

Other reason not listed above: _____

CHHD Office Use Only:

Nurse Signature: _____ Date: _____

TB / PPD Test: **Private / State**
WV - State Law / Medical Risk / Contact
Homeless/ Other Population / Administration
Foreign Born – Endemic / Non Endemic

T-Spot / IGRA: Private / State
WV State Law / Medical Risk /Contact
Homeless/ Other Population / Administration
Foreign Born – Endemic / Non Endemic

No Follow-up Needed _____