Missouri Department of Health and Senior Services
Bureau of Communicable Disease Control and Prevention

Tuberculosis (TB) Risk Assessment Form

Patient's Name: _____ **Date of Birth:**_____ **Date:** _____
Address: _____ **Phone Number:** _____

A. Please answer the following questions (Sections A & B to be completed by Patient):	
Have you ever had a positive Mantoux tuberculin skin test (TST)?	☐ Yes ☐ No
Have you ever been vaccinated with BCG?	☐ Yes ☐ No
Have you ever had a positive Interferon Gamma Release Assay (IGRA) test?	☐ Yes ☐ No
Have you ever been diagnosed with or treated for TB Disease?	☐ Yes ☐ No

B. <u>TB Risk Assessment</u>

Have you ever had close contact with anyone who was sick with tuberculosis?	☐ Yes ☐ No
Have you ever traveled to one or more of the countries listed below? **If yes, please CHECK the countries.**	☐ Yes ☐ No
Were you born in one of the countries listed below? **If yes, please list the country:**_____ What year did you arrive in the United States? _____	☐ Yes ☐ No

Afghanistan	Cape Verde	Gabon	Kuwait	Myanmar	St. Vincent &	Tokelau
Algeria	Central African Rep.	Gambia	Kyrgyzstan	Namibia	The Grenadines	Tonga
Angola	Chad	Georgia	Lao PDR	Nauru	Sao Tome & Principe	Trinidad & Tobago
Anguilla	Chile	Ghana	Latvia	Nepal	Saudi Arabia	Tunisia
Argentina	China	Greenland	Lesotho	Nicaragua	Senegal	Turkey
Armenia	Colombia	Guatemala	Liberia	Niger	Serbia	Turkmenistan
Azerbaijan	Comoros	Guinea	Libyan Arab Jamihirya	Nigeria	Seychelles Sierra	Turks & Caicos
Bahrain	Congo	Guinea-Bissau	Lithuania	Niue	Leone	Islands
Bangladesh	Congo DR	Guam	Macedonia-TFYR	Northern Mariana	Singapore	Tuvalu
Belarus	Cote d'Ivoire	Guyana	Madagascar	Islands	Solomon Islands	Uganda
Belize	Croatia	Haiti	Malawi	Pakistan	Somalia	Ukraine
Benin	Djibouti	Honduras	Malaysia	Palau	South Africa	Uruguay
Bhutan	Dominica	Hungary	Maldives	Panama	Sri Lanka	Uzbekistan
Bolivia	Dominican Republic	India	Mali	Papua New Guinea	Sudan	Vanuatu
Bosnia & Herzegovina	Ecuador	Indonesia	Marshall Islands	Paraguay	Sudan - South	Venezuela
Botswana	Egypt	Iran	Mauritania	Peru	Suriname	Viet Nam
Brazil	El Salvador	Iraq	Mauritius	Philippines	Syrian Arab Republic	Wallis & Futuna
Brunei Darussalam	Equatorial Guinea	Japan	Mexico	Poland	Swaziland	Islands
Bulgaria	Eritrea	Kazakhstan	Micronesia	Portugal	Tajikistan	Yemen
Burkina Faso	Estonia	Kenya	Moldova-Rep.	Qatar	Tanzania-UR	Zambia
Burundi	Ethiopia	Kiribati	Mongolia	Romania	Thailand	Zimbabwe
Cambodia	Fiji	Korea-DPR	Morocco	Russian Federation	Timor-Leste	
Cameroon	French Polynesia	Korea-Republic	Mozambique	Rwanda	Togo	

Source: World Health Organization Global Tuberculosis Control, WHO Report 2013, Countries with Tuberculosis incidence rates of > 20 cases per 100,000 population. For future updates, refer to http://www.who.int/topics/tuberculosis/en/.

Have you ever had an abnormal chest x-ray suggestive of TB?	☐ Yes ☐ No ☐ No Response
Are you HIV positive?	☐ Yes ☐ No ☐ No Response
Are you an organ transplant recipient or donor?	☐ Yes ☐ No ☐ No Response
Are you immunosuppressed (taking an equivalent of > 15 mg/day of prednisone for ≥1 month, or currently taking prescription arthritis medication)?	☐ Yes ☐ No ☐ No Response
Are you a resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)?	☐ Yes ☐ No ☐ No Response
Do you have any medical conditions such as diabetes, 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)?	☐ Yes ☐ No ☐ No Response
Do you have a cough lasting 3 weeks or longer, chest pain, weakness or fatigue, weight loss, chills, fever and/or night sweats?	☐ Yes ☐ No ☐ No Response
Are you coughing up blood or phlegm?	☐ Yes ☐ No ☐ No Response

I hereby certify that this application contains no misrepresentation or falsification and that the information given by me is true and complete to the best of my knowledge and belief.

_____ _____
Patient Signature (Required) Date:

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C. Medical Evaluation (Section C to be completed by Health Care Provider – if needed)

Health Care Provider: If the answer to any of the TB Risk Assessment questions in Section B is YES or NO RESPONSE, proceed with additional medical evaluation as appropriate. Additional evaluation may include one or more of the following: TST, IGRA, sign and symptom review, chest x-ray, or sputum collection. If the patient is immunosuppressed and no previous TB test is documented, an IGRA is recommended.

1. **Tuberculin Skin Test (TST) -** Please provide a 2-step TST for those at high risk that have no documentation of a previous TST: Administer 1st step TST today and read in 48-72 hrs, if the 1st step TST is positive, document the results in millimeters (mm)of induration and follow the evaluation steps for a positive TST. If the 1st step TST is negative document the results in mm of induration. Results of mm of induration, transverse diameter; if no induration write "0" mm. The TST interpretation* should be based on mm of induration as well as risk factors. Place a 2-step TST in one to three weeks after the first TST was read and recorded. The 2-step should be read in 48-72 hrs and then follow the documentation procedures as outlined above .

Date Given: _____ **Date Read:** _____
Result: _____ mm of Induration ***Interpretation:** Positive____ Negative____
Date Given: _____ **Date Read:** _____
Result: _____ mm of Induration ***Interpretation:** Positive____ Negative____

***TST Interpretation Guidelines (Please check all that apply).**

>5 mm is Positive:
- ☐ Recent close contacts of an individual with infectious TB
- ☐ Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- ☐ Organ transplant recipients
- ☐ Immunosuppressed persons: taking ≥ 15 mg/d of prednisone for ≥ 1 month; taking a TNF-α antagonist
- ☐ Persons with HIV/AIDS

>15 mm is Positive: ☐ Persons with no known risk factors for TB disease

> 10 mm is Positive:
- ☐ Persons born in a high prevalence country or who resided in one for a significant amount of time
- ☐ History of illicit drug use
- ☐ Mycobacteriology laboratory personnel
- ☐ History of resident, worker or volunteer in high-risk congregate settings
- ☐ Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes
- ☐ Children < 4 years of age
- ☐ Children and adolescents exposed to adults in high-risk categories

2. **Interferon Gamma Release Assay (Please check the IGRA that is used)**
   QFT-G ☐ QFT-GIT ☐ **Date Obtained**: _____
   Result: ☐ Responsive (TB Infection Likely) ☐ Nonresponsive (TB Infection Unlikely) ☐ Indeterminate
   T- Spot ☐ **Date Obtained**: _____
   Result: ☐ Negative ☐ Positive ☐ Borderline/Equivocal
   Other: _____ **Date Obtained**: _____ **Result:**_____

3. **Chest X-ray: (Required if TST or IGRA is positive)**
   Date of Chest X-ray: _____ **Result:** ☐ Normal ☐ Abnormal
   Abnormal Chest X-ray Interpretation: _____

4. **Sputum Collection: If the patient has a positive TST or IGRA and a productive cough > 3weeks, with or without hemoptysis,** please collect three (3) consecutive sputum, one early morning and all must be at least eight (8) hours apart with a minimum of 2 milliliters of specimen per tube.

1. Date Obtained	Smear Result:	Culture Result:	2. Date Obtained:	Smear Result:	Culture Result:
_____	_____	_____	_____	_____	_____
3. Date Obtained:	**Smear Result:**	**Culture Result:**			
_____	_____	_____			

An isolate on any positive mycobacterium cultures should be sent to the Missouri State Public Health Laboratory.

I have reviewed the above information with the patient and deemed: ☐ **No Further Evaluation Needed** ☐ **Further Evaluation is Needed**

_____ _____
Health Care Provider Signature (Required) Date:

All positive TST, IGRA, chest x-ray, smear and culture results suggestive of tuberculosis disease or latent tuberculosis infection should be reported to the Missouri Department of Health and Senior Services (fax number: 573-526-0235) or your local public health agency using this form. If you have any questions, please contact the Bureau of Communicable Disease Control and Prevention at 573-751-6113.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

MEDICAL EXAMINATION REPORT FOR CAREGIVERS AND STAFF

SAVE PRINT RESET

Patient may:
- ✓ Have contact with children (infant through school-age) in care away from their own homes.
- ✓ Be responsible for children's physical care and social development during day and/or nighttime hours.
- ✓ Need to lift children.

IDENTIFYING INFORMATION (To be completed by patient.)

NAME	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)	TELEPHONE NUMBER ( )
NAME AND ADDRESS OF CHILD CARE FACILITY WHERE EMPLOYED	

MEDICAL REPORT (To be completed by a licensed physician or advance practice nurse; by registered professional nurse or registered nurse who is under the supervision of a licensed physician.)

PHYSICAL EXAMINATION

On _____ (date), I examined this patient. I certify that to the best of my knowledge, this patient is in good physical and emotional health and free of contagious disease. ☐ Yes ☐ No

TB CLEARANCE

(Check one.)

☐ TB Risk Assessment Form attached (required)

☐ A chest x-ray or appropriate written follow-up of a previous examination that indicates the individual is free of contagion dated _____ .

LIMITATIONS

The above dated physical examination indicates this patient has the following physical or mental conditions that might endanger the health of children or might prevent the patient from providing adequate care of children:

☐ None

☐ _____

RESTRICTIONS

This patient has the following restrictions, e.g., cannot lift children who weigh more than 20 pounds, etc.

☐ None

☐ _____

REMARKS

SIGNATURES

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER SUPERVISION OF A PHYSICIAN	DATE	PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT.)
NAME AND ADDRESS OF CLINIC, GROUP PRACTICE, OTHER (PLEASE USE STAMP, IF AVAILABLE)		IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN'S NAME. (PLEASE PRINT.)
		TELEPHONE NUMBER ( )