DEPARTMENT OF
INTELLECTUAL AND
DEVELOPMENTAL DISABILITIES

Adult Tuberculosis (TB) Risk Assessment and Screening Form

This form is to be completed annually for all employees having contact with service recipients and filed in his/her employee file.

Employee Name: _____ Date Completed: _____

EMPLOYEE TO ANSWER QUESTIONS BELOW:	
Have you ever had a positive TB test or had tuberculosis? If yes, you will need to present a report to your supervisor from your health care provider about your status, including results of a chest x-ray, which has been performed in the past 6 months in the U.S.A.	☐ Yes ☐ No
TB Risk Factors	
1. Have you had contact or lived with someone who has been sick with TB in the last 2 years?	☐ Yes ☐ No
2. Were you born in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean, or the Middle East? If yes, what country?_____	☐ Yes ☐ No
3. Have you spent more than 30 days in a one of the foreign countries above in the last five years? If yes, what county/countries?_____	☐ Yes ☐ No
4. Have you ever worked or lived in a correctional facility, long-term care facility, hospital, homeless shelter, or an alcohol and drug treatment center?	☐ Yes ☐ No
5. Have you ever been an intravenous drug user?	☐ Yes ☐ No
TB Symptom Screening – At this time, do you have any of the following symptoms?	
1. Coughing for more than 2-3 weeks?	☐ Yes ☐ No
2. Coughing up blood?	☐ Yes ☐ No
3. Weight loss of more than 10 pounds without trying to lose weight?	☐ Yes ☐ No
4. Fever of 100º F (or 38º C) for over 2 weeks?	☐ Yes ☐ No
5. Unusual or heavy sweating at night?	☐ Yes ☐ No
6. Unusual weakness or extreme fatigue?	☐ Yes ☐ No
7. Loss of appetite	☐ Yes ☐ No
FOR REVIEWER USE ONLY:	
Review of Information and Required Follow-up	
Are there "yes" marks in 1 or more boxes under "TB Risk Factors"?	☐ Yes ☐ No
Are there "yes" marks in 2 or more boxes under "TB Symptom Screening"?	☐ Yes ☐ No
If one or none of the "yes" boxes in this section are checked, no follow-up is needed by the employee.	
If both of the "yes" boxes in this section are checked, the employee is to be referred to their personal physician or the local Health Department for an evaluation. A report is to be provided to the supervisor. Was employee referred to private physician/local Health Department for follow-up? If yes, date referred:_____ Reviewer Name:_____ Date Reviewed:_____	☐ Yes ☐ No