University Health Center
The University of Georgia
Athens, GA 30602-1755
706-542-8617 Health Information
706-542-4959 Fax for health forms

Name _____
SSN _____
Date of Birth _____

TUBERCULOSIS (TB) RISK ASSESSMENT (Required if risk noted on TB Screening Questionnaire)

A. Patient Section

Recent close contact with someone with infectious TB disease	☐ Yes ☐ No
Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America) ** This significance of the travel exposure should be discussed with a health care provider and evaluated.*	☐ Yes ☐ No
Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No
Organ transplant recipient	☐ Yes ☐ No
Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF-α anatagonist)	☐ Yes ☐ No
History of illicit drug use	☐ Yes ☐ No
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
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)]	☐ Yes ☐ No

B. Healthcare provider section: Discuss the significance of exposure and evaluate the patient.

1. **Does the student have signs or symptoms of active tuberculosis disease?**

   ☐ Yes Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing (TST), chest x-ray, and sputum evaluation as indicated.

   ☐ No Proceed to #2 or #3**.** Completion of either #2 or #3 is required for **all** students with any risk factor noted above.

2. **Tuberculin Skin Test (TST)** TST result must be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors. **See guidelines** listed on instructions page.**

   Date Given: ____/____/_____ (mm dd yyyy) Date Read: ____/____/_____ (mm dd yyyy)

   Result: _____ mm induration **Interpretation: positive ☐ negative ☐

3. **Interferon Gamma Release Assay (IGRA)**: Check the specific method: ☐ QFT-G ☐ QFT-GIT ☐ other _____

   Date Obtained: ____/___/_____ (mm dd yyyy) Result: ☐ Negative ☐ Positive ☐ Intermediate

4. **Chest x-ray**: Required if TST or IGRA is positive, or symptoms of active disease present. Attach a copy of the chest x-ray report to this document.

   Date of chest x-ray: ____/____/_____ (mm dd yyyy) Result: ☐ normal ☐ abnormal

5. **Sputum evaluation:** Required if TST or IGRA is positive, or symptoms of active disease present. Attach a copy of the sputum report to this document.

   Date performed: ____/____/_____ (mm dd yyyy) Result: ☐ normal ☐ abnormal

Required signature of United States or Canada Healthcare physician or healthcare facility:

Name _____ Phone _____

Address _____ City, State, Zip Code _____

Signature_____ Date_____ *10/2008*