



Tuberculosis (TB) Risk Assessment

Student's Name _____ Student's DOB _____

Persons with any of the following risk factors are candidates for either a TB skin test (PPD) or Interferon Gamma Release Assay (IGRA), UNLESS a previous positive test has been documented.

Please answer the following additional TB risk screening questions:

- 1. Does the student have HIV/AIDS? Yes No
- 2. Organ transplant recipient? Yes No
- 3. Immunosuppression (equiv to 15 mg prednisone or TNF-alfa antag)? Yes No
- 4. History of illicit drug use? Yes No
- 5. Chronic illness that may increase risk for TB progression (diabetes, silicosis, cancer, renal disease, malabsorption, or intestinal bypass)? Yes No

Does the student have signs or symptoms of active TB?

If no, then proceed to #2, If YES, then proceed with further evaluation as indicated.

2. Medical assessment

- a. Has +PPD been noted previously? Yes No
 - *If yes, then chest x-ray is required within 6 months of entry:* Date of CXR ___/___/___
Result Normal Abnormal
 - *If yes, has the patient completed a 9 mo course of INH?* Yes, completed ___/___/___
 No
- b. PPD (or IGRA) must be done if there is no history or previous positive PPD or IGRA. The PPD should be recorded as actual millimeters of induration and interpreted based on the guidelines (**) below.

Date read: ___/___/___ Result: _____ mm of induration
**Interpretation (see guidelines below) Positive Negative

c. Interferon Gamma Release Assay (IGRA) - required only if PPD was not done

Date obtained: ___/___/___
Method: QFT-G QFT-GIT Other _____
Result: Positive Negative Intermediate
If the IGRA is POSITIVE, then chest x-ray is required within 6 months of entry: Date of CXR ___/___/___
Result Normal Abnormal

****Interpretation Guidelines**

<p>>5 mm is positive:</p> <ul style="list-style-type: none"> Recent close contact with person with active TB Abnormal CXR c/w past TB disease Organ transplant or other immunosuppression HIV/AIDS 	<p>>10 mm is positive:</p> <ul style="list-style-type: none"> Significant travel or residence in high prevalence area Illicit drug use Worker in healthcare, homeless shelter, prisons Chronic health issues, as per above screening questions
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>15 mm is positive if no risk factors

HEALTH CARE PROVIDER SIGNATURE REQUIRED:

Printed Name _____ Address _____
Signature _____ Phone Number _____ Fax Number _____