



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: \_\_\_\_\_

<b>EMPLOYEE TO ANSWER QUESTIONS BELOW:</b>	
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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>TB Risk Factors</b>	
1. Have you had contact or lived with someone who has been sick with TB in the last 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Were you born in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean, or the Middle East? If yes, what country? _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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? _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever been an intravenous drug user?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>TB Symptom Screening - At this time, do you have any of the following symptoms?</b>	
1. Coughing for more than 2-3 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Coughing up blood?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Weight loss of more than 10 pounds without trying to lose weight?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Fever of 100° F (or 38° C) for over 2 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Unusual or heavy sweating at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Unusual weakness or extreme fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Loss of appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>FOR REVIEWER USE ONLY:</b>	
<b>Review of Information and Required Follow-up</b>	
Are there "yes" marks in 1 or more boxes under "TB Risk Factors"?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there "yes" marks in 2 or more boxes under "TB Symptom Screening"?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reviewer Name: _____ Date Reviewed: _____	