



Patient Tuberculosis Risk Assessment

This form should be used for any client requesting tuberculosis testing, as a screening tool to document risk prior to testing, and to determine whether testing is indicated.

FACILITY INFORMATION

Date _____

Facility/Clinic _____

Mailing address _____ Phone _____

City/State/Zip _____ Fax _____

PATIENT INFORMATION

Name (last) _____ (first) _____ DOB _____ Sex _____

Occupation _____ Country of birth _____

Mailing address _____ City _____ State _____ Zip _____

Phone number _____ Alternate contact/guardian _____

Race Caucasian Black/African American Native American/Alaskan Native Asian Unknown Other _____

Ethnicity Non-Hispanic Hispanic/Latino

Patient health insurance status: Uninsured Medicaid Medicare Private Insurance (ACA, student, employer, etc.) VA

PREVIOUS TB SCREENING OR TREATMENT

Have you previously had a TB skin or blood test? No Yes, date of last test _____ Result Neg Pos _____ mm

Have you ever received treatment for TB disease or infection? No Yes If yes please dates of treatment, location, and medications: _____

Have you ever had a vaccine for TB (BCG)? No Yes, country and date of vaccine _____

In the last 30 days have you had a live viral vaccine such as MMR, chickenpox, flu, yellow fever? No Yes, date _____

CONSENT FOR SCREENING AND TREATMENT

In accordance with state law, positive test results may be reported to the Wyoming Department of Health (WDH). As required by HIPAA law, WDH may not further use or disclose protected health information without an authorization.

Acknowledgement of Receipt of Notice of Privacy Practices: I have received and read the WDH notice of privacy practices and have had a chance to ask questions about how my information will be used.

Signature of client (or guardian) _____ Date _____

****The remainder of this document needs to be reviewed by a nurse or other clinician.****

TB SYMPTOM ASSESSMENT

A symptom review should be done with every client. Symptoms increase the risk of TB disease or progression to disease but should be evaluated in context.

Y	N	Prolonged cough (>2-3wks) with or without sputum production that may be bloody	Y	N	Diagnosis of community-acquired pneumonia that has not improved after 7 days of treatment
Y	N	Chest pain	Y	N	Unexplained weight loss
Y	N	Chills	Y	N	Weakness or easily fatigued
Y	N	Fever	Y	N	Loss of appetite
Y	N	Night sweats	Y	N	Other

Nurse/Clinician Initials _____ Date _____

Client Name _____ DOB _____

TARGETED TB RISK ASSESSMENT

Review the following risk factors before deciding to test. Clients with symptoms of TB or any of these risk factors are at a greater risk for TB infection or disease and should be tested. In clients with a history of previous positive testing or previous TB treatment, this form can be used as a symptom and risk review. If no further symptoms or risks are identified, testing may not be necessary.

Check if applicable	Employment Risks (please identify facility)
	Correctional or detention facilities
	Healthcare facility, including health care students
	Long term care facility
	Mental health or substance use facility
	Homeless shelter
	Child care facility
	Other

Check if applicable	Social Risks (please identify country or facility as needed)
	Foreign born persons from areas that have a high TB burden (e.g., Latin America, Caribbean, Africa, Asia, Eastern Europe, Russia, South America). <i>List country(ies):</i>
	Infants, children, adolescents frequently exposed to adults at high risk for TB infection
	Infants, children, adolescents with travel histories to countries with endemic infection (listed above) and substantial contact with native people from those countries. <i>List country and duration</i>
	Travelers who anticipate possible prolonged exposure to people with TB (for example, those who expect to come in contact routinely with clinic, hospital, prison, or homeless shelter populations) should have a TB skin test or a TB blood test before leaving the United States. If the test reaction is negative, they should have a repeat test 8 to 10 weeks after returning to the United States. <i>List country(ies):</i>
	Residents or former residents of high risk congregate settings (long term care facilities, mental health or substance use treatment facility, homeless shelters, correctional facility). <i>List facility(ies):</i>
	Homeless (past or current)
	Injection drug use (past or current)
	Other

Check if applicable	Clinical conditions that impact interpretation of TST (see page 4) and increase risk for progression to TB disease (Active TB).	Comments
	HIV/AIDS	
	Substance use	
	Silicosis	
	Diabetes	
	Severe kidney disease	
	Hematologic/reticuloendothelial disease	
	Cancer in head, neck, lung	
	Low body weight (10% or more below ideal)	
	Other immunosuppressive therapy including taking the equivalent of >15 mg/day of prednisone for 1 month or longer, taking TNF- α antagonists.	
	Organ transplant	
	Chronic malabsorption syndromes, gastrectomy, or jejunioileal bypass (e.g. Crohn's Disease)	
	CXR finding suggestive of previous TB disease without adequate treatment history	

CONTACT INVESTIGATION

Has client been exposed to someone with active TB disease? N Y

Name of contact _____

Nurse/Clinician Initials _____ Date _____

Client Name _____ DOB _____

No symptoms or risks identified, TB testing not indicated. Nurse/Clinician Initials _____ Date _____

TB TESTING AND TREATMENT RECORD
TESTING INFORMATION

Patients who have completed TB treatment should no longer be screened for tuberculosis infection using skin tests or interferon gamma release assays (IGRAs), as they are unreliable predictors of infection after treatment completion. Instead, any tuberculosis screening should be for active disease and only in the context of suspected reinfection due to known exposure or symptom development.

Do not place a TB skin test if the patient has a previously positive TB test, received BCG, or is foreign borne.

First Skin Test

Second Skin Test

Lot/Exp _____ Date read _____
Site _____ Time read _____
Date placed _____ Read by _____
Time placed _____ Induration _____ mm
Placed by _____ Positive Negative

Lot/Exp _____ Date read _____
Site _____ Time read _____
Date placed _____ Read by _____
Time placed _____ Induration _____ mm
Placed by _____ Positive Negative

Financial assistance for the cost IGRAs, chest x-rays, liver function test, and sputum cultures may be available for those who qualify. The Prior Authorization request form for this service can be found at <https://health.wyo.gov/publichealth/communicable-disease-unit/tuberculosis-2/>. Complete the form and submit to cdu.treatment@wyo.gov or via fax to (307) 777-5279.

IGRA Test T-SPOT QuantiFERON Gold Date drawn _____ Result Date _____ Result _____

Chest X-ray (CXR) Date _____ Results _____

HIV Test Negative Positive Refused testing Unknown

Sputum Culture Date _____ Results _____

Date _____ Results _____

Date _____ Results _____

Liver Function Testing (if applicable)

Date _____ Results _____

Date _____ Results _____

Other testing/comments _____

TREATMENT/MEDICATIONS

TB medication assistance may be available through the TB program. Please submit this completed risk assessment, lab results (if applicable), the CXR report, and copy of the prescription to the WDH TB program at cdu.treatment@wyo.gov or via fax to (307) 777-5279.

Isoniazid _____ **Prescribing provider** _____

Rifapentine _____ **Date therapy began** _____

Rifampin _____ **Date therapy completed** _____

Ethambutol _____ **Date therapy discontinued** _____

Rifabutin _____ **Reason** Death Adverse reaction Moved Lost to follow-up

Pyrazinamide _____ Diagnosed w/ active disease Non-compliant

After client completes (or discontinues) therapy fill out the Completion of Treatment Letter which can be found at <https://health.wyo.gov/publichealth/communicable-disease-unit/tuberculosis-2/> and submit to cdu.treatment@wyo.gov or via fax to (307) 777-5279.

Nurse/Clinician (signature & credentials) _____ Date _____

Comments: _____

Nurse/Clinician (signature & credentials) _____ Date _____

INTERPRETING MANTOUX TUBERCULIN TESTS

Important Skin Testing information:

The skin test reaction should be read between 48 and 72 hours after administration by a health care worker trained to read TST results. A patient who does not return within 72 hours will need to be rescheduled for another skin test.

The reaction should be measured in millimeters of the induration (firm swelling). The reader should **not** measure erythema (redness). The diameter of the indurated area should be measured across the forearm (perpendicular to the long axis).

Classification of the Tuberculin Skin Test Reaction		
<p>An induration of 5 or more millimeters is considered positive in:</p> <ul style="list-style-type: none"> -People living with HIV -A recent contact of a person with infectious TB disease - People with chest x-ray findings suggestive of previous TB disease -People with organ transplants -Other immunosuppressed people (e.g., patients on prolonged therapy with corticosteroids equivalent to/greater than 15 mg per day of prednisone or those taking TNF-a antagonists) 	<p>An induration of 10 or more millimeters is considered positive in:</p> <ul style="list-style-type: none"> -People born in countries where TB disease is common, including Mexico, the Philippines, Vietnam, India, China, Haiti, and Guatemala, or other countries with high rates of TB -People who abuse drugs or alcohol -Mycobacteriology laboratory workers -People who live or work in high-risk congregate settings (e.g., nursing homes, homeless shelters, or correctional facilities) -People with certain medical conditions that place them at high risk for TB (e.g., silicosis, diabetes mellitus, severe kidney disease, certain types of cancer, and certain intestinal conditions) -People with a low body weight (<90% of ideal body weight) -Children younger than 5 years of age -Infants, children, and adolescents exposed to adults in high-risk categories 	<p>An induration of 15 or more millimeters is considered positive in:</p> <ul style="list-style-type: none"> -People with no known risk factors for TB

Reference: 5/17/2021 <https://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm>

*Additional instructions/recommendations may apply to individuals seeking care through a Civil Surgeon. Please reference the recommendations at <http://www.cdc.gov/ncidod/dq/civil.htm>.