



Missouri Department of Health and Senior Services  
Bureau of Communicable Disease Control and Prevention  
**Tuberculosis (TB) Risk Assessment Form**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**A. Please answer the following questions (Sections A & B to be completed by Patient):**

- Have you ever had a positive Mantoux tuberculin skin test (TST)?  Yes  No
- Have you ever been vaccinated with BCG?  Yes  No
- Have you ever had a positive Interferon Gamma Release Assay (IGRA) test?  Yes  No
- Have you ever been diagnosed with or treated for TB Disease?  Yes  No

**B. TB Risk Assessment**

- Have you ever had close contact with anyone who was sick with tuberculosis?  Yes  No
- Have you ever traveled to one or more of the countries listed below? **If yes, please CHECK the countries.**  Yes  No
- Were you born in one of the countries listed below? **If yes, please list the country:** \_\_\_\_\_  Yes  No
- What year did you arrive in the United States? \_\_\_\_\_

Afghanistan	Cape Verde	Gabon	Kuwait	Myanmar	St. Vincent & The Grenadines	Tokelau
Algeria	Central African Rep.	Gambia	Kyrgyzstan	Namibia	Sao Tome & Principe	Tonga
Angola	Chad	Georgia	Lao PDR	Nauru	Saudi Arabia	Trinidad & Tobago
Anguilla	Chile	Ghana	Latvia	Nepal	Senegal	Tunisia
Argentina	China	Greenland	Lesotho	Nicaragua	Serbia	Turkey
Armenia	Colombia	Guatemala	Liberia	Niger	Seychelles Sierra Leone	Turkmenistan
Azerbaijan	Comoros	Guinea	Libyan Arab Jamihirya	Nigeria	Singapore	Turks & Caicos Islands
Bahrain	Congo	Guinea-Bissau	Lithuania	Niue	Solomon Islands	Tuvalu
Bangladesh	Congo DR	Guam	Macedonia-TFYR	Northern Mariana Islands	Somalia	Uganda
Belarus	Cote d'Ivoire	Guyana	Madagascar	Pakistan	South Africa	Ukraine
Belize	Croatia	Haiti	Malawi	Palau	South Africa	Uruguay
Benin	Djibouti	Honduras	Malaysia	Panama	Sri Lanka	Uzbekistan
Bhutan	Dominica	Hungary	Maldives	Papua New Guinea	Sudan	Vanuatu
Bolivia	Dominican Republic	India	Mali	Paraguay	Sudan - South	Venezuela
Bosnia & Herzegovina	Ecuador	Indonesia	Marshall Islands	Peru	Suriname	Viet Nam
Botswana	Egypt	Iran	Mauritania	Philippines	Syrian Arab Republic	Wallis & Futuna
Brazil	El Salvador	Iraq	Mauritius	Poland	Swaziland	Islands
Brunei Darussalam	Equatorial Guinea	Japan	Mexico	Portugal	Tajikistan	Yemen
Bulgaria	Eritrea	Kazakhstan	Micronesia	Qatar	Tanzania-UR	Zambia
Burkina Faso	Estonia	Kenya	Moldova-Rep.	Romania	Thailand	Zimbabwe
Burundi	Ethiopia	Kiribati	Mongolia	Russian Federation	Timor-Leste	
Cambodia	Fiji	Korea-DPR	Morocco	Rwanda	Togo	
Cameroon	French Polynesia	Korea-Republic	Mozambique			

Source: World Health Organization Global Tuberculosis Control, WHO Report 2013, Countries with Tuberculosis incidence rates of > 20 cases per 100,000 population. For future updates, refer to <http://www.who.int/topics/tuberculosis/en/>.

- Have you ever had an abnormal chest x-ray suggestive of TB?  Yes  No  No Response
- Are you HIV positive?  Yes  No  No Response
- Are you an organ transplant recipient or donor?  Yes  No  No Response
- Are you immunosuppressed (taking an equivalent of > 15 mg/day of prednisone for ≥1 month, or currently taking prescription arthritis medication)?  Yes  No  No Response
- Are you a 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  No Response
- Do you have any medical conditions such as diabetes, 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)?  Yes  No  No Response
- Do you have a cough lasting 3 weeks or longer, chest pain, weakness or fatigue, weight loss, chills, fever and/or night sweats?  Yes  No  No Response
- Are you coughing up blood or phlegm?  Yes  No  No Response

**I hereby certify** that this application contains no misrepresentation or falsification and that the information given by me is true and complete to the best of my knowledge and belief.

\_\_\_\_\_  
Patient Signature (Required)

\_\_\_\_\_  
Date:



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**C. Medical Evaluation (Section C to be completed by Health Care Provider – if needed)**

**Health Care Provider: If the answer to any of the TB Risk Assessment questions in Section B is YES or NO RESPONSE, proceed with additional medical evaluation as appropriate. Additional evaluation may include one or more of the following: TST, IGRA, sign and symptom review, chest x-ray, or sputum collection. If the patient is immunosuppressed and no previous TB test is documented, an IGRA is recommended.**

- Tuberculin Skin Test (TST)** - Please provide a 2-step TST for those at high risk that have no documentation of a previous TST: Administer 1st step TST today and read in 48-72 hrs, if the 1st step TST is positive, document the results in millimeters (mm) of induration and follow the evaluation steps for a positive TST. If the 1st step TST is negative document the results in mm of induration. Results of mm of induration, transverse diameter; if no induration write "0" mm. The TST interpretation\* should be based on mm of induration as well as risk factors. Place a 2-step TST in one to three weeks after the first TST was read and recorded. The 2-step should be read in 48-72 hrs and then follow the documentation procedures as outlined above .

<b>Date Given:</b> _____	<b>Date Read:</b> _____
<b>Result:</b> _____ mm of Induration	<b>*Interpretation:</b> Positive____ Negative____
<b>Date Given:</b> _____	<b>Date Read:</b> _____
<b>Result:</b> _____ mm of Induration	<b>*Interpretation:</b> Positive____ Negative____

**\*TST Interpretation Guidelines (Please check all that apply).**

- |   |   |
|---|---|
| <p><b>&gt;5 mm is Positive:</b> <input type="checkbox"/> Recent close contacts of an individual with infectious TB</p> <p><input type="checkbox"/> Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease</p> <p><input type="checkbox"/> Organ transplant recipients</p> <p><input type="checkbox"/> Immunosuppressed persons: taking <math>\geq 15</math> mg/d of prednisone for <math>\geq 1</math> month; taking a TNF-<math>\alpha</math> antagonist</p> <p><input type="checkbox"/> Persons with HIV/AIDS</p> <p><b>&gt;15 mm is Positive:</b> <input type="checkbox"/> Persons with no known risk factors for TB disease</p> | <p><b>&gt; 10 mm is Positive:</b> <input type="checkbox"/> Persons born in a high prevalence country or who resided in one for a significant amount of time</p> <p><input type="checkbox"/> History of illicit drug use</p> <p><input type="checkbox"/> Mycobacteriology laboratory personnel</p> <p><input type="checkbox"/> History of resident, worker or volunteer in high-risk congregate settings</p> <p><input type="checkbox"/> Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (&gt;10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes</p> <p><input type="checkbox"/> Children &lt; 4 years of age</p> <p><input type="checkbox"/> Children and adolescents exposed to adults in high-risk categories</p> |
|---|---|

- Interferon Gamma Release Assay (Please check the IGRA that is used)**

QFT-G  QFT-GIT  **Date Obtained:** \_\_\_\_\_

**Result:**  Responsive (TB Infection Likely)  Nonresponsive (TB Infection Unlikely)  Indeterminate

T- Spot  **Date Obtained:** \_\_\_\_\_

**Result:**  Negative  Positive  Borderline/Equivocal

Other: \_\_\_\_\_ **Date Obtained:** \_\_\_\_\_ **Result:** \_\_\_\_\_

- Chest X-ray: (Required if TST or IGRA is positive)**

**Date of Chest X-ray:** \_\_\_\_\_ **Result:**  Normal  Abnormal

**Abnormal Chest X-ray Interpretation:** \_\_\_\_\_

- Sputum Collection: If the patient has a positive TST or IGRA and a productive cough > 3weeks, with or without hemoptysis, please collect three (3) consecutive sputum, one early morning and all must be at least eight (8) hours apart with a minimum of 2 milliliters of specimen per tube.**

<b>1. Date Obtained</b> _____	<b>Smear Result:</b> _____	<b>Culture Result:</b> _____	<b>2. Date Obtained:</b> _____	<b>Smear Result:</b> _____	<b>Culture Result:</b> _____
<b>3. Date Obtained:</b> _____	<b>Smear Result:</b> _____	<b>Culture Result:</b> _____			

An isolate on any positive mycobacterium cultures should be sent to the Missouri State Public Health Laboratory, for further testing questions call 573-751-3334.

**I have reviewed the above information with the patient and deemed:**  **No Further Evaluation Needed**  **Further Evaluation is Needed**

\_\_\_\_\_  
 Health Care Provider Signature (Required)

\_\_\_\_\_  
 Date:

All positive TST, IGRA, chest x-ray, smear and culture results suggestive of tuberculosis disease or latent tuberculosis infection should be reported to the Missouri Department of Health and Senior Services (fax number: 573-526-0235) or your local public health agency using this form. If you have any questions, please contact the Bureau of Communicable Disease Control and Prevention at 573-751-6113.