## Tuberculosis Program TB Signs, Symptoms and Risk Factor Screening Form

Name:	Date of Birth:		
Si	gns and Symptoms of TB Disease		
Persons who answer "yes" to any of the following signs and symptoms warrant further investigation to rule out active infectious pulmonary/laryngeal TB.		Yes	No
1. Productive	cough of more than three (3) weeks duration		
2. Coughing up blood			
Persistent fevers			
4. Drenching night sweats			
5. Unplanned weight loss			
	TB Risk Factors		
Persons who answer "yes" to the following risk factors for TB should be referred to the local health department or health care provider for evaluation, to include a TB skin test or IGRA (unless there is a documented history of a past positive test) and a chest x-ray as needed.		Yes	No
Persons at risk for exposure to persons with TB disease	Close contact to a person with infectious TB Disease		
	Immigration from a part of the world with high rates of TB		
	Resident or employee of high-risk congregate setting (e.g., correctional facility, homeless shelter, health care facility)		

TB Risk Factors Continued			No		
Persons more likely to progress from Inactive TB/LTBI to TB disease	HIV-infected person				
	Children younger than 5 years of age				
	People recently infected with TB bacteria (within the last 2 years)				
	People with a history of untreated or inadequately treated TB Disease				
	Person receiving immunosuppressive therapy such as tumor necrosis factor alpha (TNF) antagonists, systemic corticosteroids equivalent to greater than 15 mg prednisone per day or immunosuppressive drug therapy following organ transplantation.				
	People with Silicosis; chronic renal failure; leukemia; or cancer of head, neck, or lung				
	People with Diabetes mellitus				
	Jejunoileal bypass or Gastrectomy				
	Low body weight <90% of ideal body weight				
	People who use substances such as injection drug use				
	Chronic renal failure or being on hemodialysis				
	Solid organ transplant				
	Populations defined locally as having increased incidence of TB disease, including medically underserved and low-income populations				
Name of Healthcare Provider/Clinic Person was Referred to:					
This assessment was completed by (print name):					
Signature:	Date of assessment:				