University of the Virgin Islands

Tuberculosis (TB) Risk Assessment Form

Patient's Name: ______________________________ **Date of Birth:**____________ **Date:** _____________

Address: ____ **ID #:** ____________________

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. <u>TB Risk Assessment</u>	
Have you ever had close contact with anyone who was sick with tuberculosis?	☐Yes ☐ No
Have you traveled out of the country in the last six months? **If yes, please list the country and length of stay:** ____________________ ____________________	☐Yes ☐ No
Have you ever had an abnormal chest x-ray suggestive of TB?	☐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:

______________________________ ______________________________

Signature of Parent/Guardian (if patient is under 18) Date: (Parent/Guardian if patient is under 18)